ARIZONA DEPARTMENT OF HEALTH SERVICES
OFFICE OF VITAL RECORDS
FETAL DEATH TRAINING MANUAL

Version 08-2013

FETAL DEATH TRAINING MANUAL

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FETAL DEATH TRAINING MANUAL

ARS Title 36, Chapter 3, Article 3
§36-329. Fetal death certificate registration
A. A hospital, abortion clinic, physician or midwife shall submit a completed fetal death certificate to the state registrar for registration **within seven days after the fetal death for each fetal death occurring in this state after a gestational period of twenty completed weeks or if the product of human conception weighs more than three hundred fifty grams**.
B. The requirements for registering a fetal death certificate are the same as the requirements for registering a death certificate prescribed in section 36-325.

Click below for Arizona Administrative Code Rules governing:

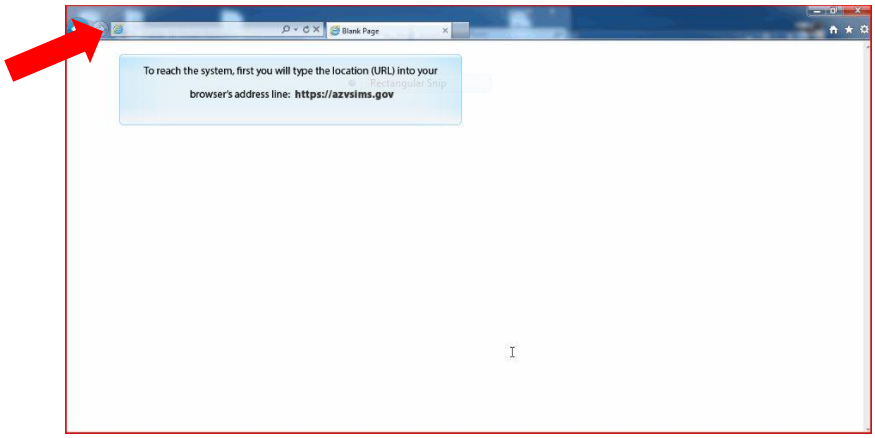
- RULES: Arizona Administrative Code for Fetal Death Certificate Registration
- Human Remains Release Form

NOTE to HOSPITAL AND COUNTY USERS: all sections must be completed unless otherwise indicated.

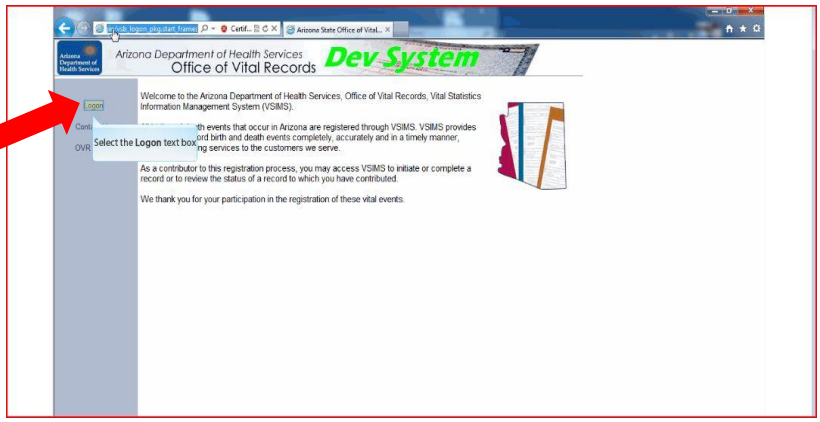
NOTE to O.M.E. USERS: those sections that are required to be completed by the O.M.E. are highlighted by a blue triangle as seen on the left.

Note: For the purposes of this training, the terms "certificate" and "record" will be used interchangeably"

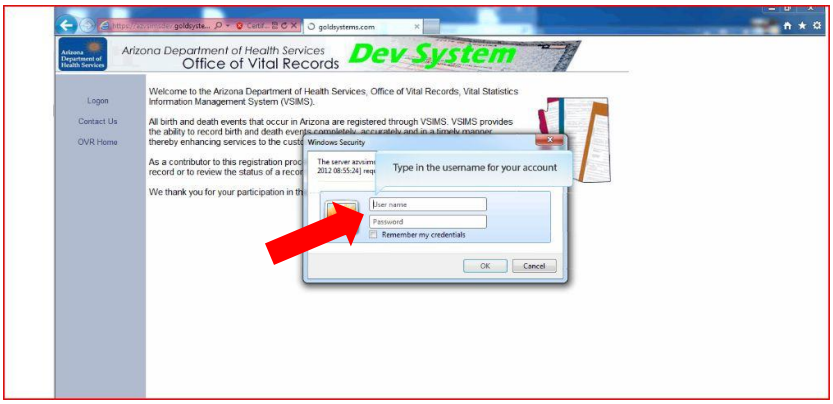
CHAPTER 1 - LOGGING IN TO VSIMS AND NAVIGATION



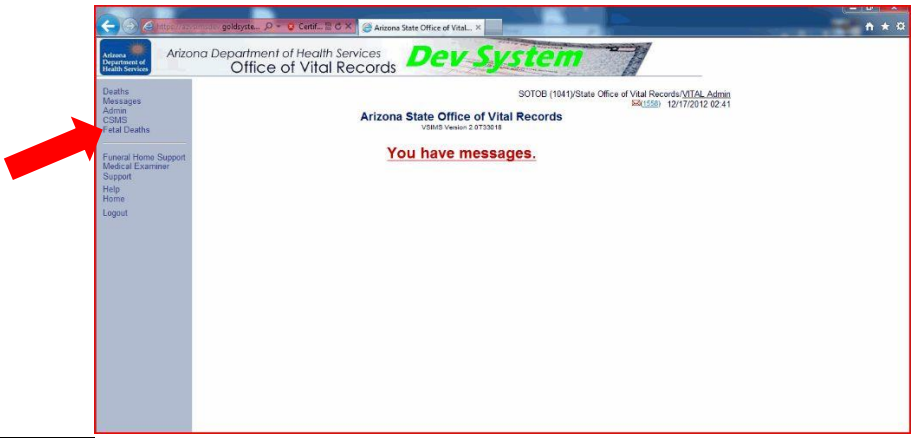
1) To access the Fetal Death application, login by typing the location (URL) – https://azvsims.gov - into the *browser address line and pressing "Enter". (*Note: while EDRS only supports Explorer, the new Fetal Death system supports Explorer, Firefox, Chrome, and Safari.)



2) That should take you to the “Logon” screen. Click “Logon” on the Menu in the column on the left side of the screen. (The other selections in that column are “Contact Us” and “OVR Home”.



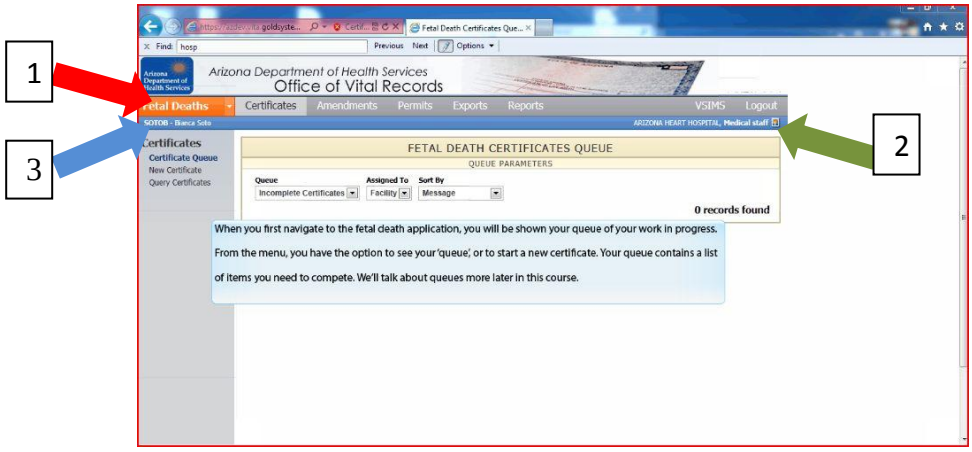
3) Once you select “Logon”, a dialogue box will open and you will be asked to enter your assigned User Name and Password then press “OK”.



4) Once you have Logged on, the Homepage will open. There will be a number of selections in the left column. The list depends on your user rights, so the list may look slightly different than the one in this example. Select “Fetal Deaths” and the Fetal Death module will open.

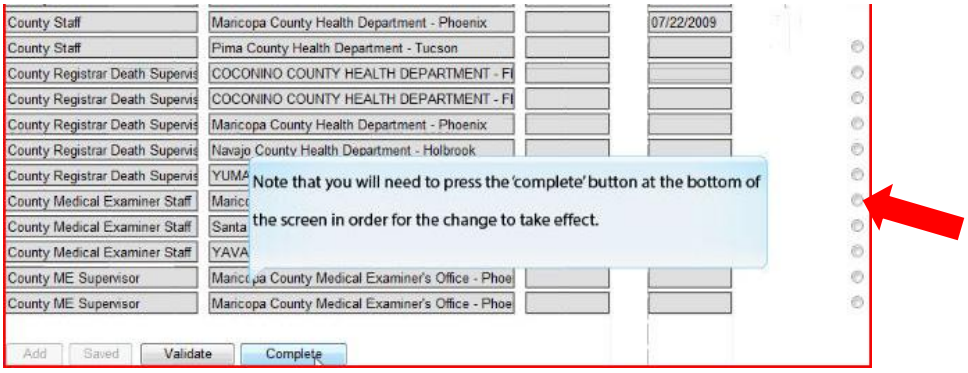
5) When you navigate to the Fetal Death module, you will first see your queue of work in progress. Your queue contains a list of items you need to complete. The Certificate Queue is the default screen for this

application, but from here you will also be able to access New Certificates and Query Certificates from the menu in the left column. You will have the choice of seeing your queue or starting a new certificate. (Queues will be discussed later in the course; Starting a New Record is covered in Chapter 2) The 3rd option is to query the database for fetal death certificates.



6) Across the top of the screen there is a bar with several selections. *(**red** arrow [1] above)*
   - "***Certificates***" clicking this will take to the Certificates section of this application.
   - "***Permits***" will take you to the Permits (FD Disposition Transit Permits) section of the application. The default page in this section of the application is the "Permits" queue, but from there you can also access the New Permits and Query Permits pages.
   - ***VSIMS*** (far right) – selecting this will take you to back to the Homepage of VSIMS
   - ***Logout*** (far right) – selecting this will log you out of the application.
   - ***Assignment(s)*** – some users may have multiple assignments, e.g. work at different hospital or birthing center locations. While using the application you may only represent one assignment at a time, so that the system knows what privileges to grant you and which facility you are associated with. Even if you have the same job at two different facilities, that is considered two assignments. Your current assignment is shown in the upper right corner of the screen (*see **green** arrow [2] above*). Your User ID and Name is shown on the far left. (*see **blue** arrow [3] above*)

7) Left navigation bar has the following options:
   - Certificate Queue
   - New Certificate
   - Query Certificate
   - Support – this link provides access to training materials and notes for users



- ***Changing Assignments*** - If you have more than one assignment, the assignment information includes a link (*small box next to the assignment*) which will take you to a page where you can view your alternate assignments and change your current assignment. (*See above*) Select the radio button next to the assignment you wish to represent during your session in the system (***red*** *arrow above*). *Note you will need to press the "Complete" button at the bottom of the screen for the change to take effect.

CHAPTER 2 - HOW TO START A NEW RECORD

NEW FETAL DEATH CERTIFICATE

1. DUPLICATE CHECK

1) To create a new record, you first have to perform a duplicate check to make sure the record has not already been started by another user or facility. To perform a duplicate check and start a new record select the menu choice "New Certificate" from the menu on the left side of the screen. (***red*** *arrow [1] above*)

2) When the duplicate check screens opens, enter: (***green*** *arrow [2] above*)
   - Last Name of the Child
   - Mother's Name Prior to First Marriage
   - Date of delivery
   - Press "Search"
   - *Note: if the child has not been named, there is a check box to indicate that.

3) If no existing records match the data you entered, click "Create New Certificate" at the bottom of the page to start a new fetal death record. (***blue*** *arrow [3] above*)

1) If one or more existing records match the criteria you entered, those records will display in a list.
   - If you see that the record you are about to create exists, you can access that record by clicking the "Edit" button to the right of the record to continue working on it. (***red*** *arrow [1] above*)
   - If the record you are about to create is not a duplicate, click on the "Create New Certificate" button at the bottom of the page to start a new Fetal Death Record (***green*** *arrow [2] above*)

2) Once you either select "Edit for an existing record or "Create New Certificate", you will bring up the fetal death record data entry pages associated with the selected or new record. The record is divided into several pages to make it easier to access and enter data without much scrolling and to allow you to save sections. The first page to open is the Child Information page which is described in the next chapter.

3) **If this is a Fetal Death (gestational age of more than 20 weeks or more than 350 grams delivery weight) please DO NOT check the box "*Is this a Report of Fetal Loss*"**. (***blue*** *arrow [3] above*)

CHAPTER 3 - DATA ENTRY

When you are entering a new certificate or completing one that you have already started, you will need to enter data into the Child Information fields. If starting a new certificate, you will notice that the information you entered in the duplicate check was carried over when you selected "Create New Certificate". (Child's Last Name, Date of Delivery, and Name of Mother Prior to First Marriage)

2. CHILD INFORMATION

- The certificate header on the Child Information Screen is a block of information above each data entry page that displays important information about the record and contains data entry navigation and action buttons. The following data points are displayed in each header:
  - ***Date of Delivery*** (Top Left) (***red*** *arrow [1] above)*
  - ***Child Full Name*** (Top Center) (***green*** *arrow [2] above*)
  - ***Certificate Type*** (Top Right) (***blue*** *arrow [3] above*)

  *Note: **200X Certificate** = Fetal Death; **200X Fetal Loss** = Report of Fetal Loss

- The following navigation and action buttons are also in the header on the above screen.
  - "***Previous***" (Left) button is visible on all but the Child Information page. Clicking this will save any changes to the current page and then navigate to the previous data entry page.
  - "***Next***" (Left) is visible on all but the Disposition Data Entry page. When clicked, will save any changes to the current page and then navigate to the next data entry page. (***green*** *arrow [2] above*)
  - "***Save***" (Left) appears on all data entry pages and when clicked saves any changes to the current page.
  - "*****Send to M.E.***" (Right) will send the record to the Medical Examiner's office at the County of the facility where you are logged in.

NOTE: HOSPITAL USERS - Do Not Use above option unless directed by County Vital Records.

  - "***Complete***" (Right) will start the process for submitting the record for data entry approval which will be discussed later in the course. (***blue*** *arrow [3] above*)

3. NAME AND DELIVERY INFORMATION

NOTE TO O.M.E. USERS: If this is a case for the County Office of the Medical Examiner, the **Name and Delivery Information** section will need to be completed by the Medical Examiner.

1) ***Name and Delivery information***: enter the child's name and delivery information. If the child was not named, select the "Child Not Named" check box. *Please note, if you select the "Child Not Named"

option, this will remove all of the child's name information previously entered. The Last Name filed must be completed with either Mother's maiden name or Father's name if available.

- **O.M.E. Users - If there is no identifying information for the Child, enter: First Name "Unidentified", Last Name "Unidentified". If the Gender of the child is known, enter First Name "Unidentified", Last Name "Male" or "Female".**
- **O.M.E. Users – If the mother name is known, for consistency sake, it is best for the O.M.E, to select the "Child Not Named" box and enter mother's maiden name in the Child's Last Name field rather than leaving it blank.**

2) ***Sex***: gender options - Male, Female, and Unknown

3) ***Date of Delivery*** – enter the date of delivery. If the date of delivery is not known, select "Unknown".

4) ***Time of Delivery*** – can be entered in am/pm or in military time. The system will automatically convert the time to military time when you click "Save". If Time of Delivery is unknown, select "Unknown"

5) ***Plurality*** – if this was a multiple delivery, you can select the appropriate number in the drop down under "Plurality".
   - If this was a single birth, when you select "single", the "Specify Order" option will not be an option.
   - If this was not a single birth, select the order in the options under "If not Single Birth, Specify Order" drop down.

4. PLACE OF DELIVERY

For definitions and additional instructions on PLACE OF DELIVERY ***Click Here***

NOTE TO HOSPITAL USERS – the entire **Place of Delivery** section will be automatically completed by the system. You will not need to enter any information in this section.

NOTE TO O.M.E. USERS: If this is a case for the County Office of the Medical Examiner, the **Place of Delivery** section will need to be completed by the Medical Examiner.

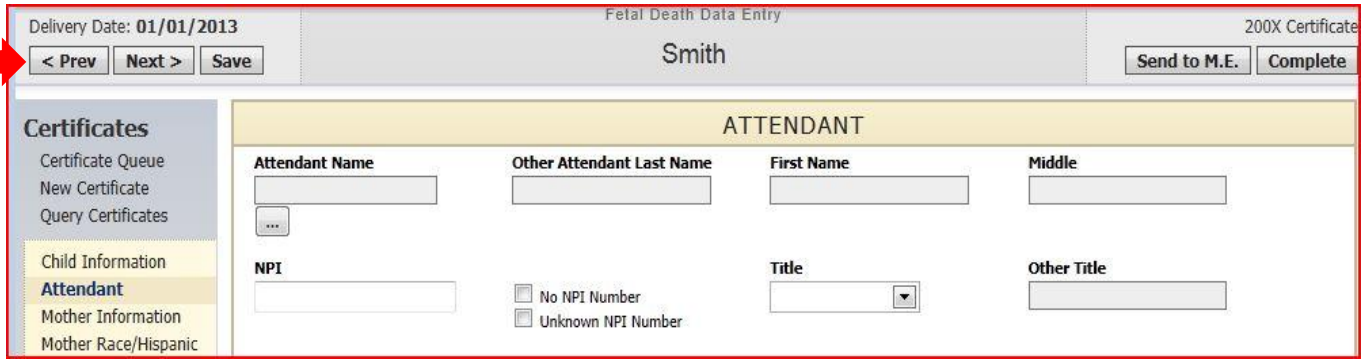
1) ***Place of Delivery*** – enter information related to where the delivery took place.
   - Enter the Zip Code and click to do a Zip Code search. The city, county and state will be automatically completed. "Other" or "Unknown" are available options. If you need to enter a city that is not found, you can use "Specify Other City of Delivery".
   - **O.M.E. Users – Select "Other" or "Unknown" under "Place of Delivery" from the dropdown available**.
     - **If you select "Other", enter the information in "Other Place of Delivery" text field.**
     - **Note* If you select "Other" or "Unknown" under Place of Delivery, the "Facility of Delivery" is no longer available as a dropdown.**

2) ***Save*** - When you have completed all the sections on this page, click on the "Next" button at the top of the page to save. All information will be saved if you click on "Next", "Save", or "Complete".

5. ATTENDANT

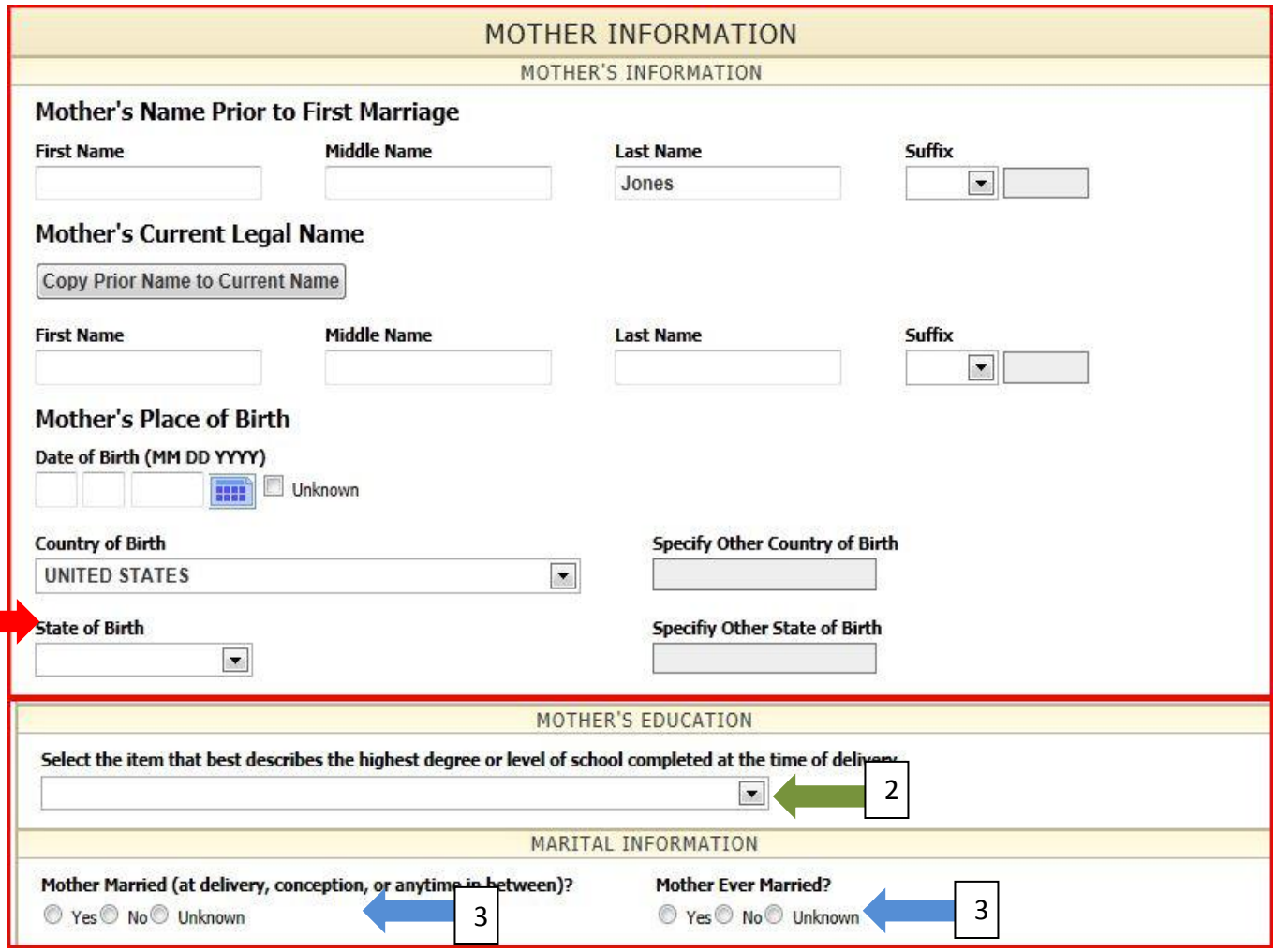
NOTE TO O.M.E. USERS: If this is a case for the County Office of the Medical Examiner, the **Attendant** section will need to be completed by the Medical Examiner.

1



1) ***Attendant Page*** – (Note* when you reach the Attendant page, you will notice that you now have a "Previous" button at the top in addition to the "Next" and "Save" buttons – (***red*** *arrow [1*] above). To complete the attendant page, select the "Attendant" from the drop down. If the attendant is not in the drop down, you can select "Other" and enter that individual's information, including their NPI and title, in the "Other Attendant" Last Name, First Name, Middle, and NPI. You can select "Title" by either selecting one of the title options in the drop down, or select "Other" and enter the individual's title in the "Other Title" field.
2) ***Add Attendant***
   - **NOTE TO HOSPITAL USERS**: If the attendant is not in the drop down list, you should also send an email to VSIMS support at VSIMSSupport@AZDHS.gov and request that they be added to the list. You will be required to provide the attendant's full name and NPI.
   - **NOTE TO O.M.E. USERS: For Attendant Name, enter "Not" for First Name and "Attended" for Last Name.**
     - **For Title select "Other"**
     - **In the Other Title text field, enter "None"**
     - **For NPI number, select "None".**

6. MOTHER INFORMATION



NOTE TO O.M.E. USERS: If this is a case for the County Office of the Medical Examiner, completing the **Mother's and Father's Information** sections is optional.

1) ***Mother's name prior to first marriage*** - on the Mother's Information page, enter the mother's name prior to first marriage.

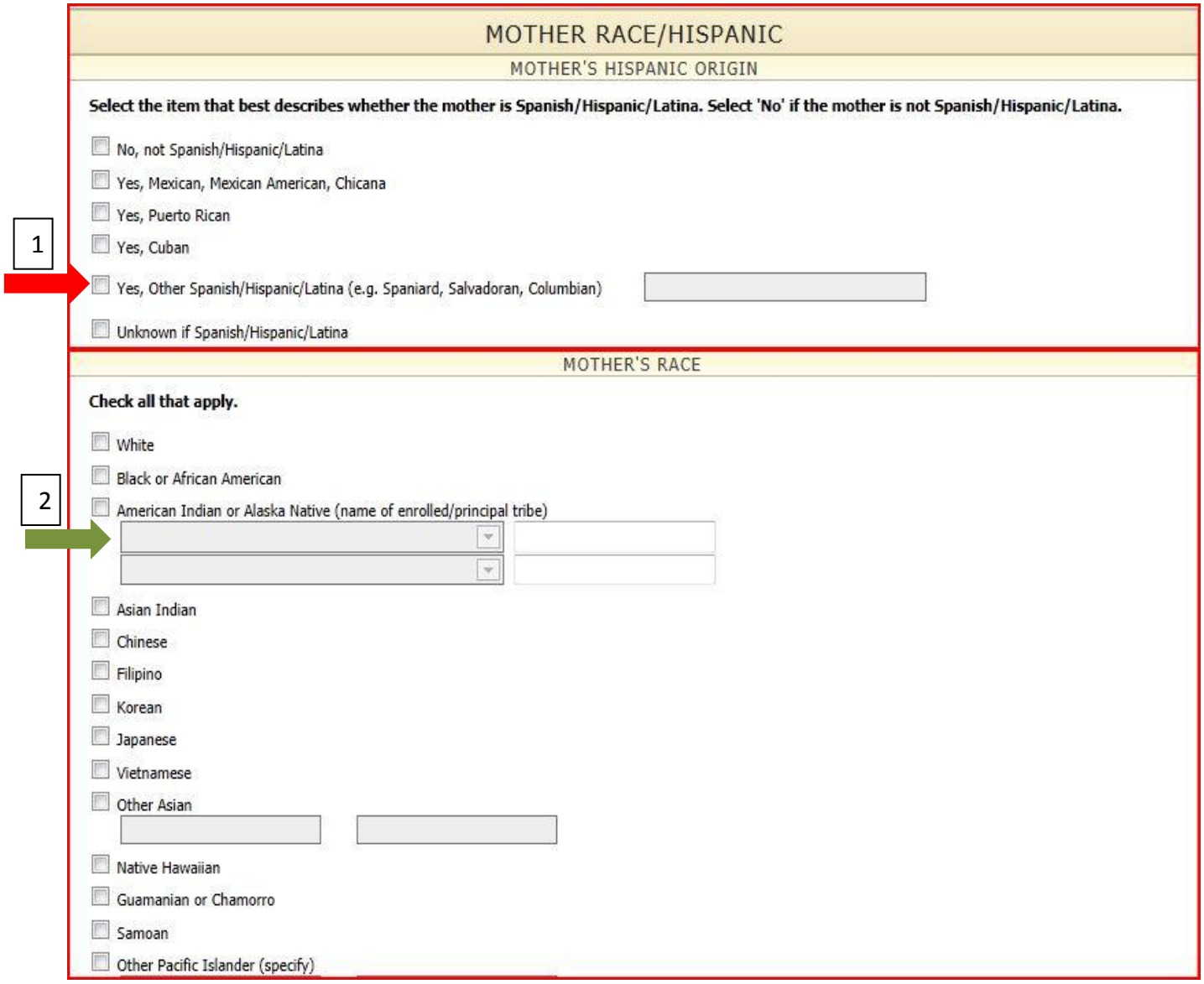
2) ***Mother's current legal name*** – next enter mother's current legal name. The "Copy Prior Name to Current Name" option is available if mother's name prior to first marriage and current legal name are the same.

3) ***Mother's place of birth*** – enter mother's birth information: date of birth, place of birth – including country and state. If mother was not born in the United States, select "Other" and complete the "Other Country" and "Other State" of birth fields.
   - ***NOTE***: Puerto Rico, Guam, Virgin Islands, American Samoa, and Northern Marianas are considered **STATES** as part of the United States. They are included in the drop down list of US states. (***red*** *arrow [1] above*)

4) ***Mother's Education*** – enter mother's educational level from the drop down options provided. (**green** arrow [2] above) The drop down options are based on US educational standards.

5) ***Marital Status*** - enter mother's marital information from the options in that section. (See above)
   - If mother refuses to give an answer regarding her marital status, select "Unknown"
   - **NOTE**: both questions regarding marital status must be answered (**blue** arrows [3] above)
   - **NOTE**: **Acknowledgement of Paternity is <u>not</u> required**

7. MOTHER RACE/HISPANIC



Mother's Hispanic Origin – select all that apply. If you enter "Yes, other" enter the appropriate information in the text field provided. (***red*** *arrow [1] above*)

Mother's Race – select all that apply. if you select a check box that has a drop down, e.g. American Indian or Alaskan Native, you will need to enter the correct information from the drop down. If the

information is not in the drop down, select “other” and enter information in the text field provided. (**green** arrow [2] above)

- **NOTE**: when entering race information in the text field(s), enter only the name of the principal tribe. **Do not enter percentages or abbreviations**.
- ***Click here for a list of Arizona Tribes***

8. MOTHER ‘S ADDRESS INFORMATION

Mother’s Address – in the “Mother’s Address” section, provide the current full address for the mother, including if the address is within city limits.

- If it is a rural community, a descriptive address should be added in the street name field.
- If the mother is homeless and living in a shelter, enter the address of the shelter; or enter the street where the mother typically sleeps; or list “Unknown”.
- If the address is within an Arizona Tribal community, please select it from the drop down list. (***red*** *arrow above*)
- No PO Boxes should be used.
- If mother does not live in the United States, select the appropriate country from the drop down. If the country is not found, enter the information in the “Other Country” text field provided. Enter “Other State” and/or “Other County” as appropriate for the Country.

9. FATHER'S INFORMATION

1) Father's ***Information*** – in the section labeled "Father' Information" enter father's current legal name, place of birth, and education just as you did for the mother.
   - If there is no father or mother does not want to name the father, list "**Not**" in the First Name field and "**Listed**" in the Last Name field.

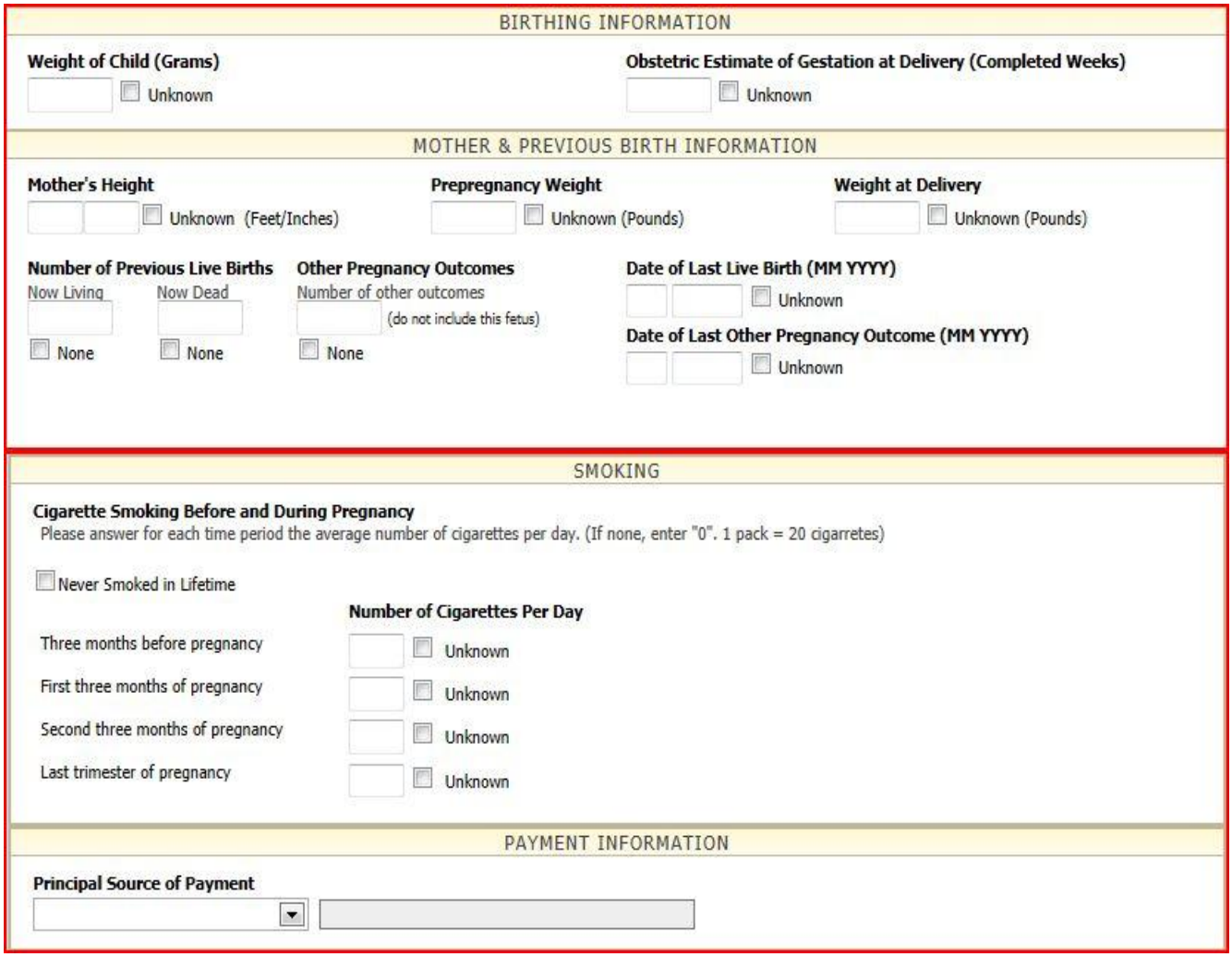
2) ***Father's Hispanic Origin and Father's Race*** – select all options that apply. As is the Mother's sections, if you select an option that has a drop down or text boxes, you will need to provide specific information. If you select "Other", you will need to complete the text field provided.
   - **NOTE**: when entering race information in the text field(s), enter only the name of the principal tribe. Do not enter a percentage.

CHAPTER 4 – BIRTH INFORMATION

10. PRENATAL INFORMATION

For definitions and additional instructions on Birth Information ***Click Here***

NOTE TO O.M.E. USERS: If this is a case for the County Office of the Medical Examiner, the **Birth Information** sections (10, 11, 12, 13, 14) below must be completed by the Medical Examiner .



1) ***Last Menses*** – enter date of mother's last normal menses began; or check "Unknown".

2) ***WIC*** – did the mother receive WIC food for herself during this pregnancy – Yes/No/Unknown.

3) ***First and Last Prenatal Care Visits*** – enter dates of the first and last prenatal care visits. You can also enter if there was no prenatal care or if the information is unknown.

4) **Total Number of Prenatal Care Visits** – enter the total number of prenatal care visits during this pregnancy. If "None" enter "0".

5) ***Prenatal Record*** – indicate if the prenatal record was available for completion of the fetal death or not.

11. BIRTHING INFORMATION

1) ***Weight*** – enter the child's weight at birth in grams if known, or select "Unknown".

2) ***Gestation*** - enter the complete weeks of gestation at delivery in weeks, or check "Unknown".

- **REMINDER: Fetal Death = more than 20 weeks gestation or greater than a delivery weight of 350 grams.**
- **NOTE: if the record was started as a Fetal Death, but the fetus does not meet the above criteria, you must delete the record and start a new record for Report of Fetal Loss.**

12. MOTHER AND PREVIOUS BIRTH INFORMATION

1) ***Mother's Height/Weight*** – enter mother's height in feet and inches or select "Unknown", prepregnancy weight in pounds or select "Unknown", and weight at delivery in pounds or select "Unknown".

2) ***Previous live births*** – enter number of previous live births; number of live births now deceased; and/or enter "None"

3) ***Other pregnancy outcomes*** – enter the number of other pregnancy outcomes, or check "None".

4) ***Live births*** – enter date of last live birth, or enter "Unknown"

5) ***Other pregnancy outcomes*** – enter date of last other pregnancy outcome if applicable, or enter "Unknown".

13. SMOKING

1) ***Non-smoker*** - If mother is a non-smoker, click "Never smoked in lifetime"
2) ***Smoker*** - If mother is a smoker, enter the number of cigarettes per day leading up to the birth.

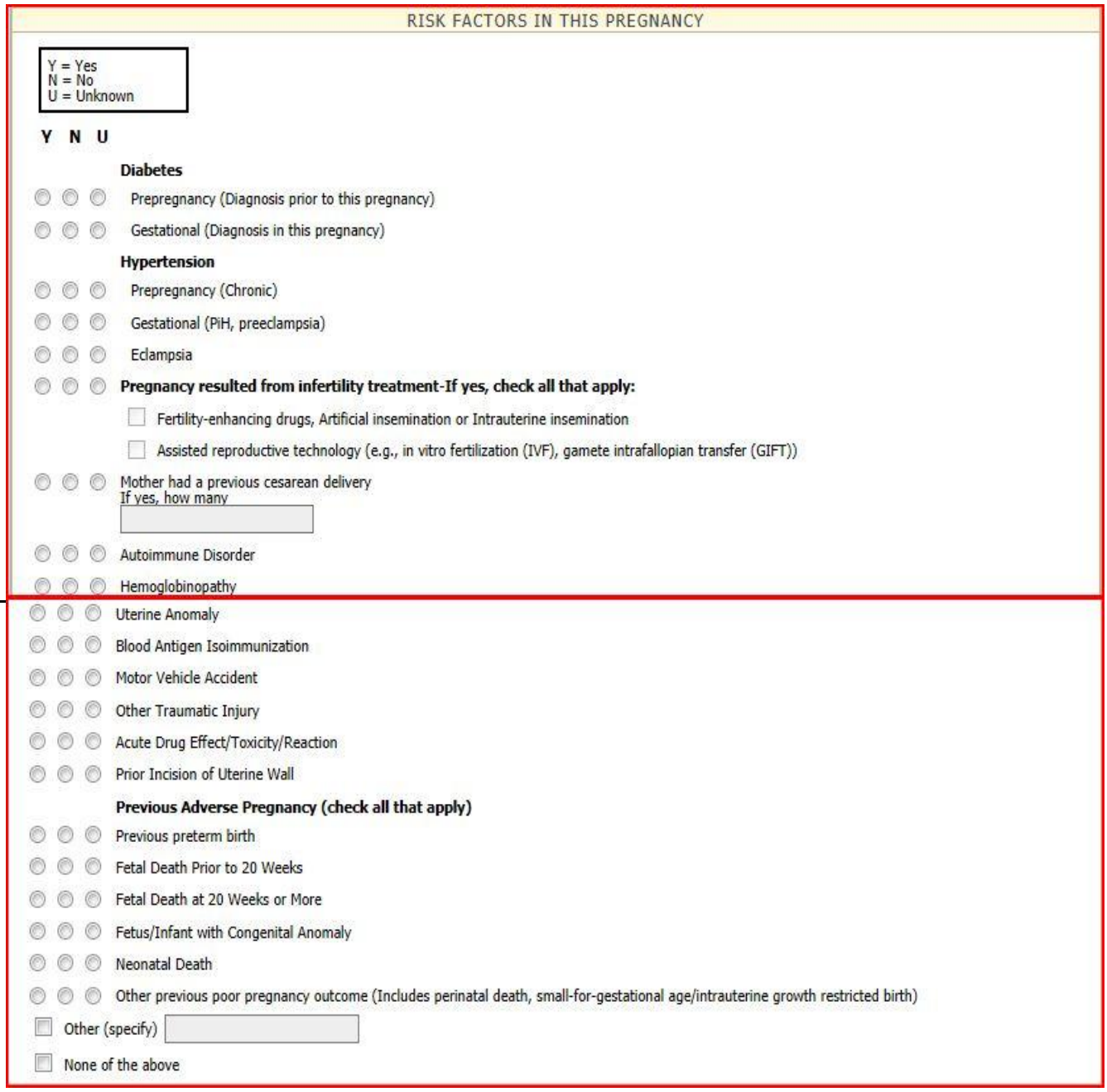
14. PAYMENT INFORMATION

1) ***Payment*** - Select the principal payment source from the drop down. If the principal payment source is not listed, select "Other" and enter the information in the text field provided.
NOTE TO O.M.E. USERS: if the Office of the Medical Examiner started the record, the O.M.E will select "Unknown" in this field.

15. MEDICAL RISK FACTORS

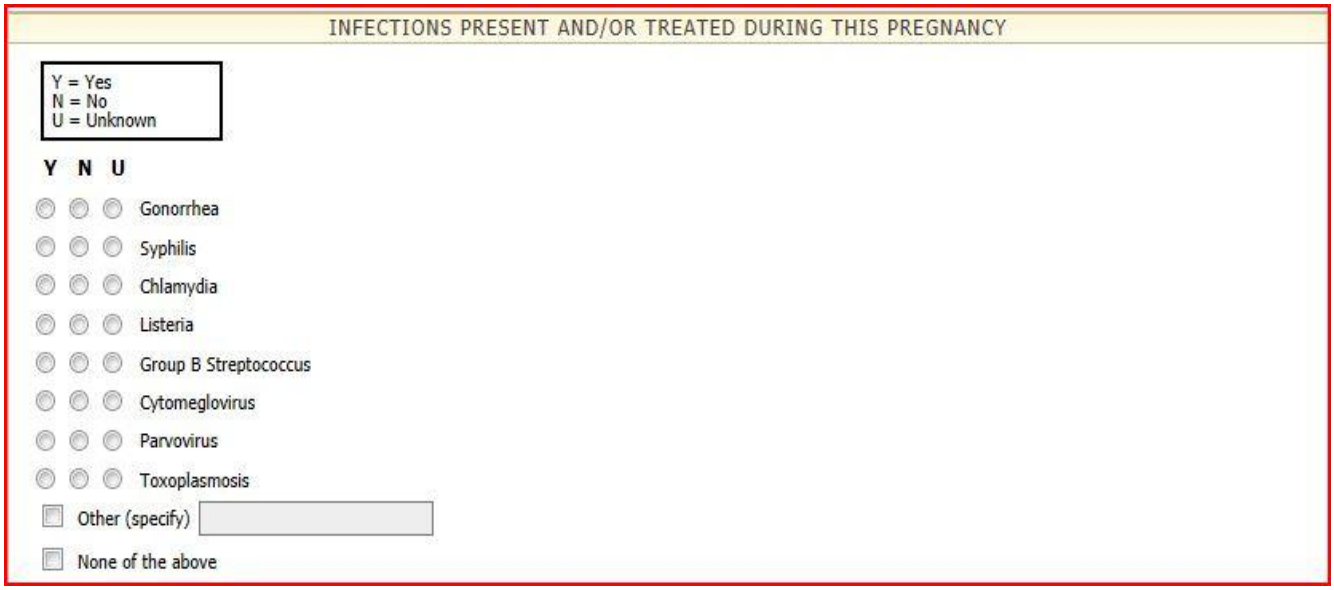
For definitions and additional instructions on MEDICAL RISK FACTORS ***Click Here***

NOTE TO O.M.E. USERS: If this is a case for the County Office of the Medical Examiner, the section on **Medical Risk Factors** below must be completed by the Medical Examiner.



❖ **RISK FACTORS IN THIS PREGNANCY** – indicate “Yes”, “No”, “Unknown” for each of the questions presented.

- If you select “Yes” on certain questions in the Risk Factors in Pregnancy section, more information will be required.
- You also have the option at the bottom of the section to check “None of the Above” at the bottom of the section which will default all answers to “No”.
- Check all boxes that apply. The mother may have more than one risk factor. If the mother has none of the risk factors, check “none of the above.”



❖ **INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY**

- Indicate "Yes", "No", "Unknown" for each of the questions presented

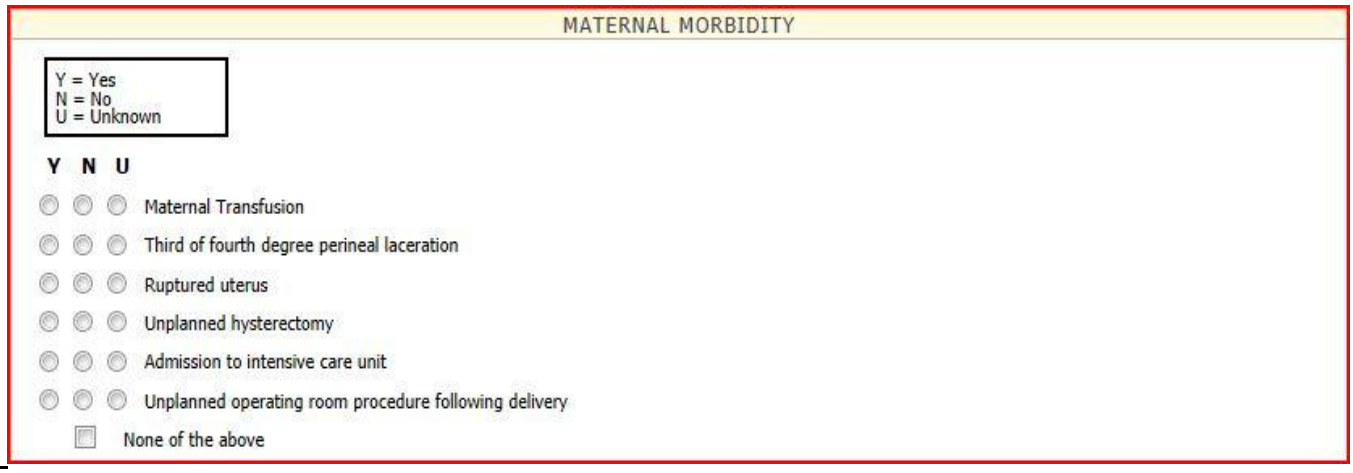
- You have the option of selecting "Other" for Toxoplasmosis. If "Other" is checked, you will be required to enter details in the field provided.

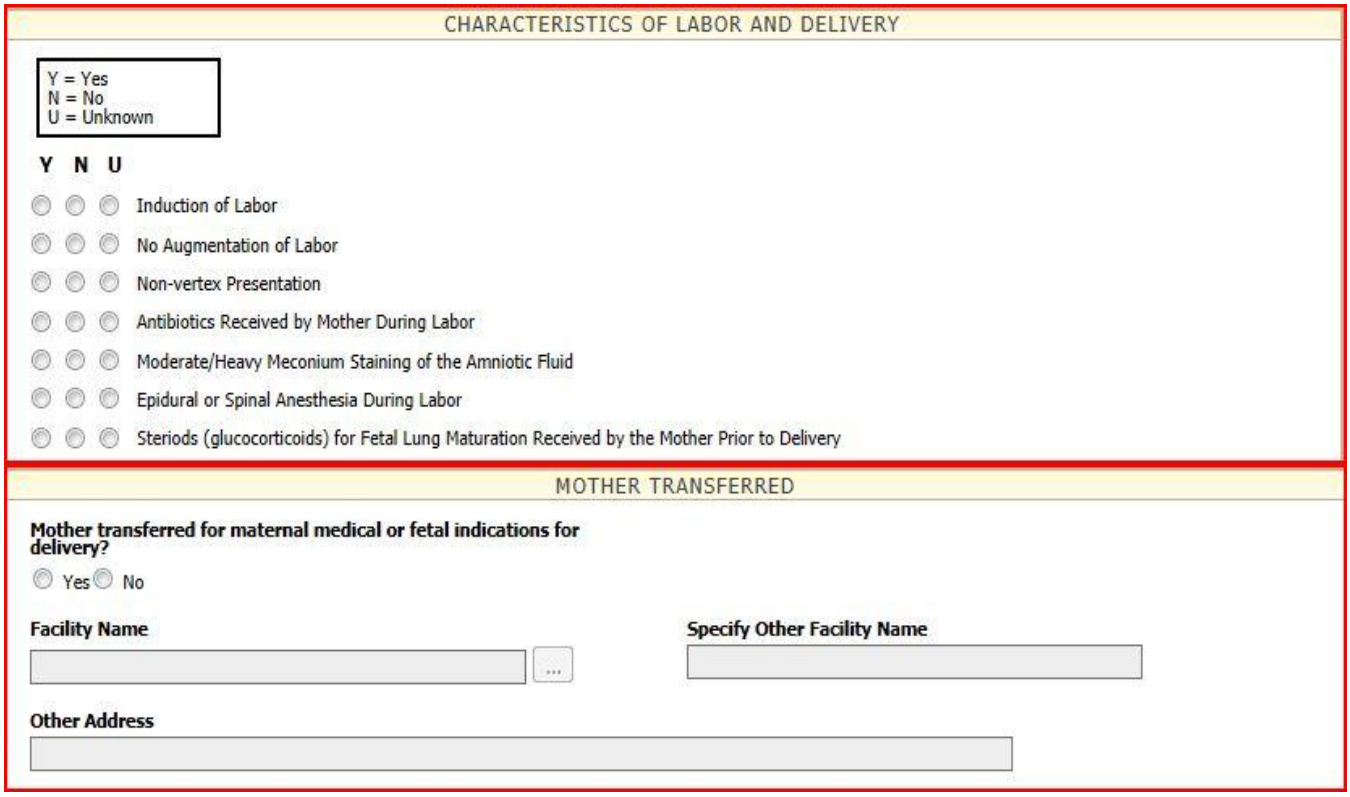
- You also have the option to check "None of the Above" at the bottom of the section which will default all answers to "No".

16. LABOR AND DELIVERY

For definitions and additional instructions on LABOR AND DELIVERY ***Click here***

NOTE TO O.M.E. USERS: If this is a case for the County Office of the Medical Examiner, the sections on **Labor and Delivery** below must be completed by the Medical Examiner.





Maternal Morbidity – in the Maternal Morbidity section, you will need to enter "Yes", "No", "Unknown" for each of the questions presented.

- You also have the option to check "None of the Above" at the bottom of the section which will default all answers to "No".

Characteristics of Labor and Delivery - in the Characteristics of Labor and Delivery section, you will need to enter Yes/No/Unknown for each of the questions presented.

Mother Transferred – indicate "Yes", "No", "Unknown" if mother was transferred for maternal medical or fetal indications for delivery.

- If "Yes" you will need to select a facility from the drop down or select "Other" and enter the other facility name and address.

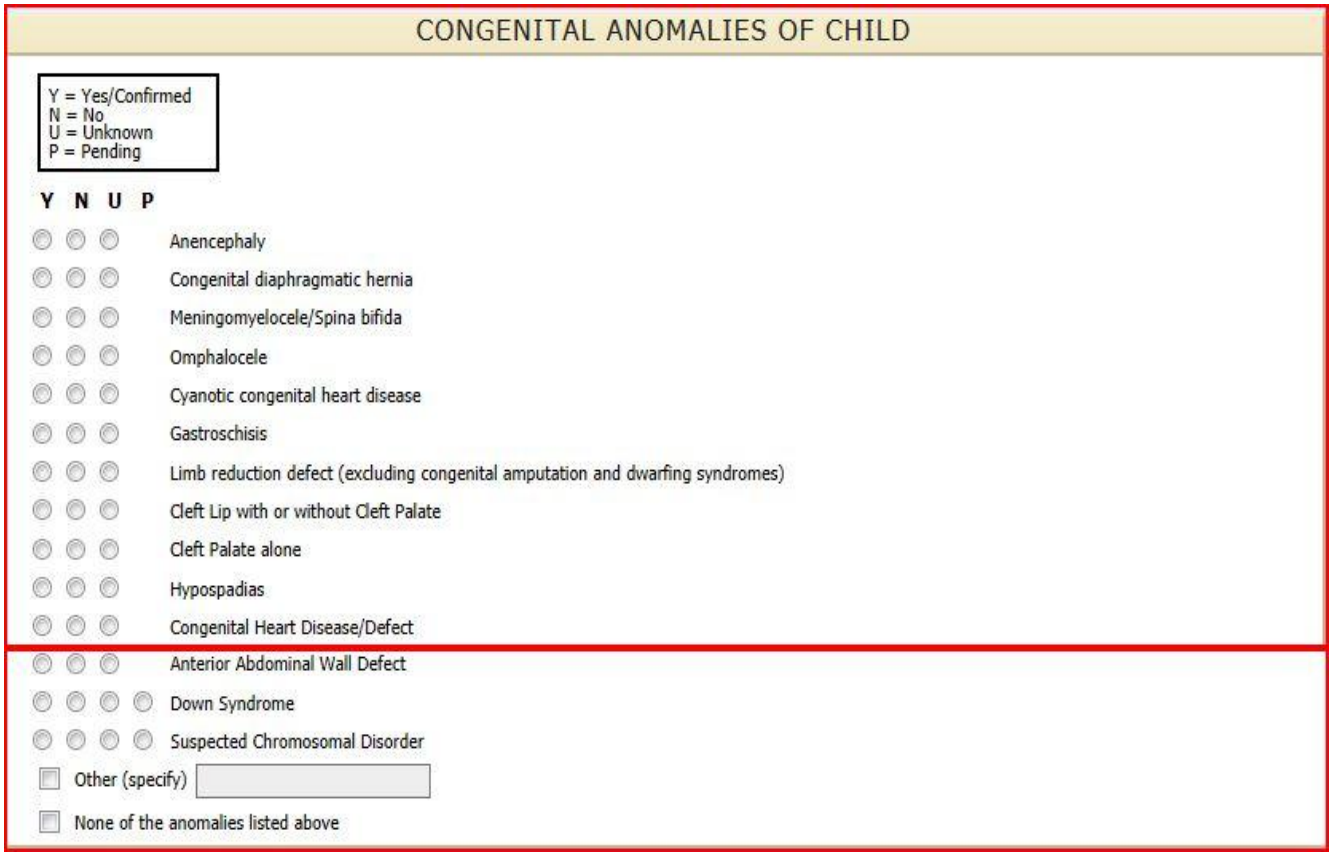
17. CONGENITAL ANOMALIES OF CHILD

For definitions and additional instructions on Congenital Anomalies Click Here

NOTE TO O.M.E. USERS: If this is a case for the County Office of the Medical Examiner, the section on **Congenital Anomalies of Child** below must be completed by the Medical Examiner.

Congenital Anomalies of Child – you will need to enter "Yes", "No", "Unknown" or "Pending" for each of the questions presented.

- You also have the option to check "None of the Above" at the bottom of the section which will default all answers to "No".

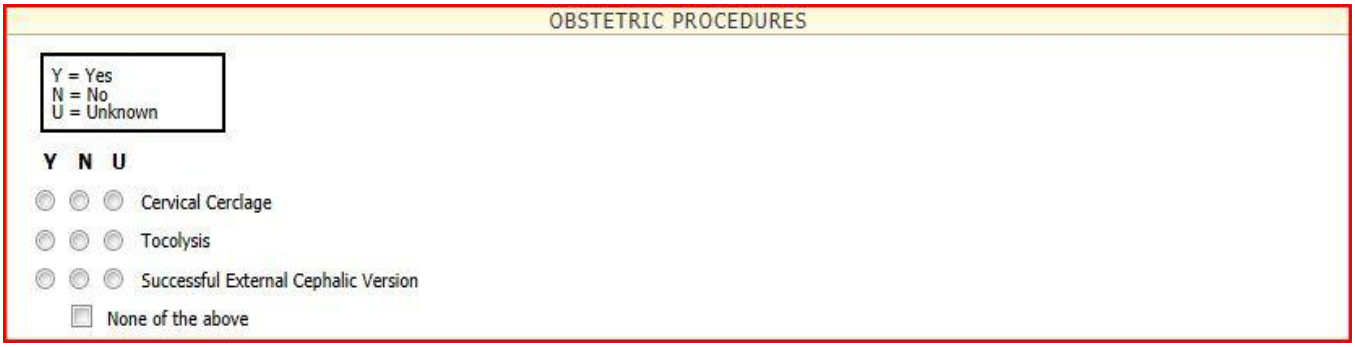


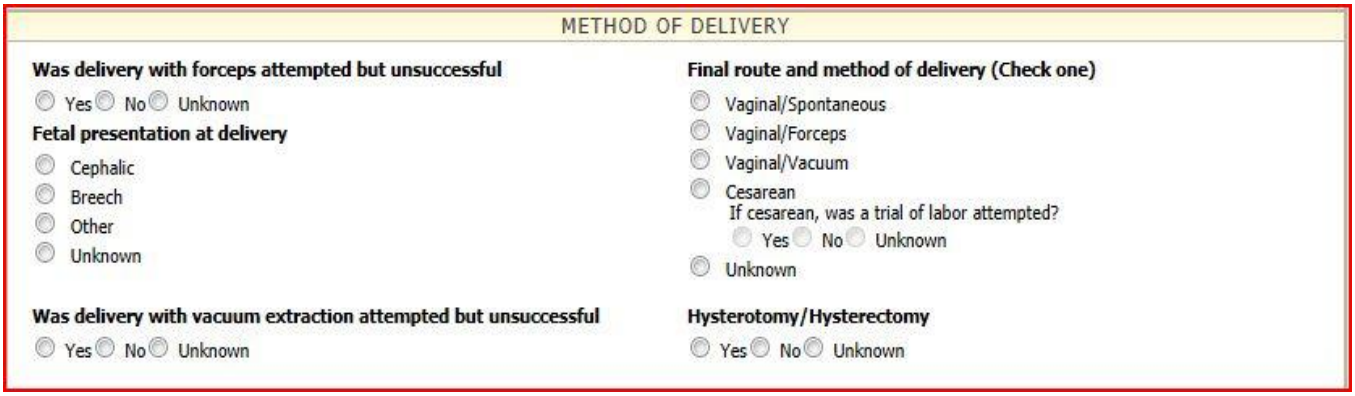
18. OBSTETRIC PROCEDURES

NOTE TO O.M.E. USERS: If this is a case for the County Office of the Medical Examiner, the sections on **Obstetric Information** (18, 19) below must be completed by the Medical Examiner.

Obstetric Procedures – enter "Yes", "No" or "Unknown" for each of the questions presented.

- You also have the option to check "None of the Above" at the bottom of the section which will default all answers to "No".



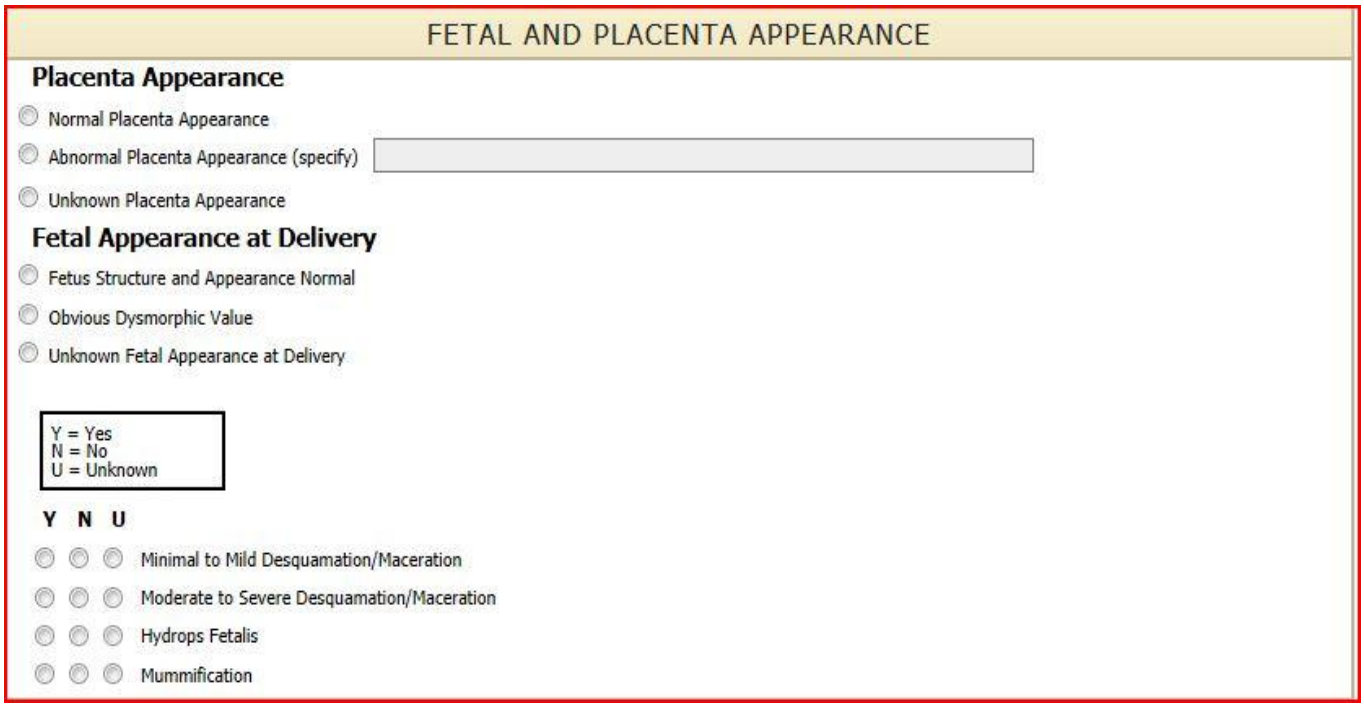


19. METHOD OF DELIVERY

Method of Delivery – indicate "Yes", "No" or "Unknown" in each of the sections where applicable.

20. FETAL AND PLACENTA APPEARANCE

NOTE TO O.M.E. USERS: If this is a case for the County Office of the Medical Examiner, the sections on **Fetal and Placenta Appearance** below must be completed by the Medical Examiner.

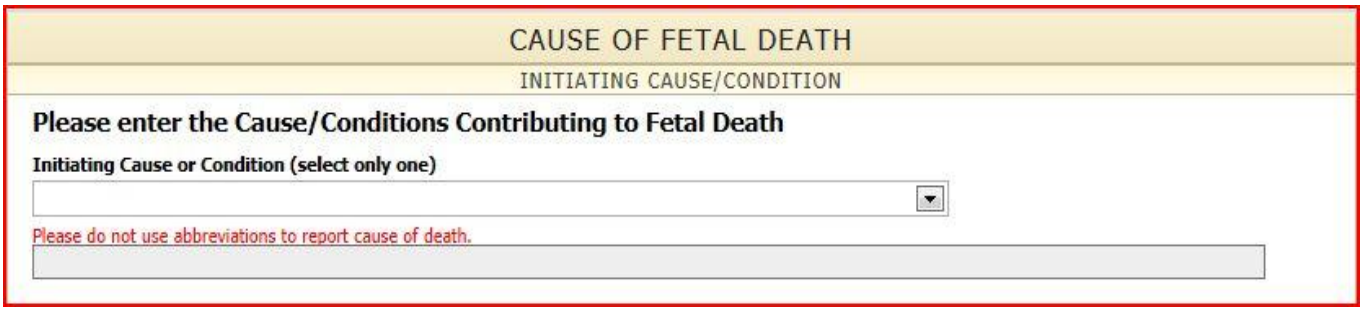


1) ***Placenta Appearance*** – select the appropriate response to the placenta appearance – Normal, Abnormal, or Unknown
2) ***Fetal Appearance*** – select the appropriate response to the fetal appearance – Normal, Abnormal, or Unknown
   - You will also need to answer "Yes", "No", or "Unknown" to the questions regarding Fetal appearance at the bottom of the screen.

CHAPTER 5 – CAUSE OF DEATH

21. INITIATING CAUSE/CONDITIONS

NOTE TO O.M.E. USERS: If this is a case for the County Office of the Medical Examiner, the sections on **Cause of Fetal Death** (21, 22, 23) below must be completed by the Medical Examiner.

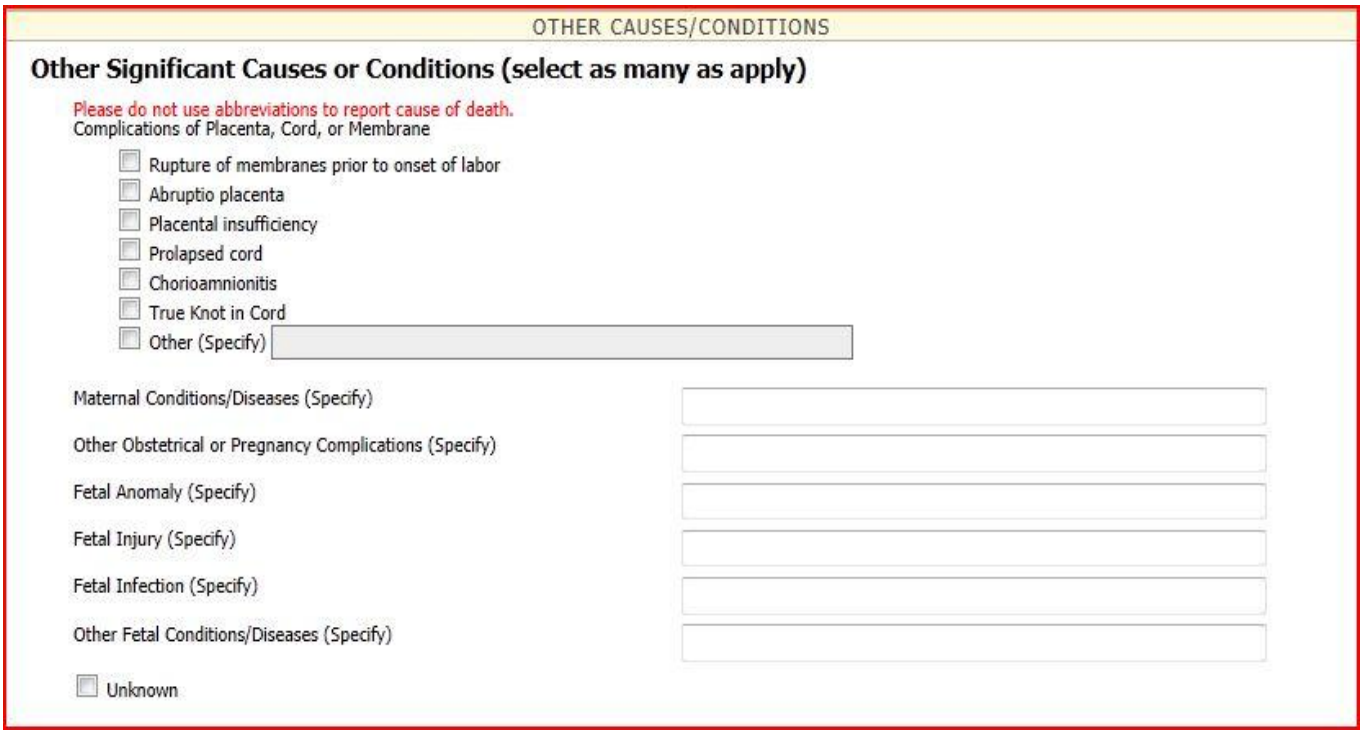


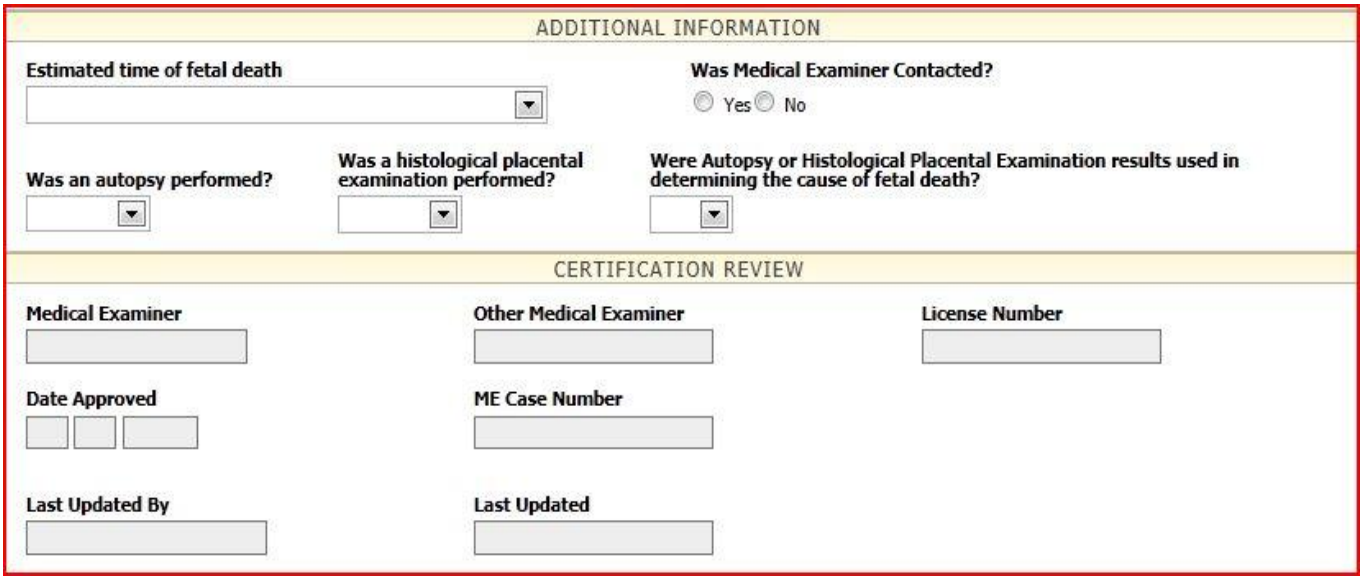
In the Initiating Cause of Death and Conditions section, select the condition from the drop down list, or select "Specify" and enter the cause in the field provided.

****PLEASE DO NOT USE ABBREVIATIONS TO REPORT CAUSE OF DEATH EVEN IF IT IS COMMONLY USED AS A MEDICAL TERM. ALSO, PLEASE BE SPECIFIC ABOUT THE CAUSE OF DEATH; DO NOT INCLUDE EXTRA DETAILS.**

- **Examples of Causes of Death that should not be used**
  - **"Expired"**
  - **"This is the 2nd fetal demise for this mother"**

22. OTHER CAUSES/CONDITIONS





****PLEASE DO NOT USE ABBREVIATIONS TO REPORT OTHER CAUSES/CONDITIONS EVEN IF IT IS COMMONLY USED AS A MEDICAL TERM. ALSO, PLEASE BE SPECIFIC ABOUT THE CAUSE OF DEATH; DO NOT INCLUDE EXTRA DETAILS.**

1) In the Other Causes and Conditions section, enter the maternal conditions and/or diseases that may have contributed to the cause of death. **Please do not enter "None" or "Unknown"**. Either be specific about the condition or leave the field blank. You will also need to check any complications of the placenta, cord, or membrane.

2) If this information is not available, select "Unknown" at the bottom of the screen.

23. ADDITIONAL INFORMATION

Select the appropriate answers from the drop down lists provided for:

- Estimated time of fetal death
- Was an Autopsy Performed
- Was a Histological Placental Examination Performed
- Were Autopsy or Histological Examination Results Used in the Determining the Cause of Fetal Death.
- Was O.M.E. contacted.
    - **NOTE TO HOSPITAL USERS: Typically Hospitals would not be contacting/referring a case to the Medical Examiner. Hospitals will select "NO" in response to this question.**
    - In most cases referrals to the Medical Examiner (M.E.) will come from the County, e.g.:
        - If the case is referred at any point in the workflow and the M.E. accepts case
        - If it is a cremation authorization
        - Case may be referred to M.E. but M.E. does not accept case

24. CERTIFICATION REVIEW

NOTE TO O.M.E. USERS: If this is a case for the County Office of the Medical Examiner, the section on **Certification Review** must be completed by the Medical Examiner.

ATTACHMENTS

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CHAPTER 19. DEPARTMENT OF HEALTH SERVICES
VITAL RECORDS AND STATISTICS

ARIZONA ADMINISRATIVE CODE
ARTICLE 3. VITAL RECORDS FOR DEATH

R9-19-301 – Human Remains Release Form
R9-19-306 - Information for a Fetal Death Certificate

R9-19-301-B. Human Remains Release Form

B. A form required by A.R.S. § 36-326(C) to accompany human remains from a fetal death moved from a hospital, nursing care institution, or hospice inpatient facility shall include:
1. The name and street address of the hospital, nursing care institution, or hospice inpatient facility;
2. The name of the mother;
3. The date of delivery;
4. The estimated gestational age or, if the gestational age is unknown, the weight of the human remains;
5. The name and telephone number of the parent authorizing the hospital, nursing care institution, or inpatient hospice facility to release the human remains;
6. A list of the circumstances in A.R.S. § 11-593(A);
7. Whether the notification required in A.R.S. § 11-593 was made;
8. For a fetal death that occurs in a hospital, if the human remains have been accepted for donation by an organ procurement organization under A.R.S. Title 36, Chapter 7, Article 3, and the person authorized in A.R.S. § 36-843 has not made or refused to make an anatomical gift, whether the organ procurement organization has been notified that the human remains are being removed from the hospital; and
9. The name and signature of the individual representing the hospital, nursing care institution, or hospice inpatient facility who released the human remains.

C. An individual who removes human remains from a hospital, nursing care institution, or hospice inpatient facility shall sign and date the human remains release form required in subsection (A) when the individual removes the human remains from the hospital, nursing care institution, or hospice inpatient facility.

D. The individual in subsection (C) who removes human remains shall submit a copy of the human remains release form required in subsection (A) to the local registrar or deputy local registrar of the registration district where the deceased individual died within 24 hours after removing the human remains from a hospital, nursing care institution, or hospice inpatient facility.

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R9-19-306. Information for a Fetal Death Certificate

A. A hospital, abortion clinic, physician, or midwife shall submit the following information for a fetal death certificate to the state registrar within seven days of a deceased's fetal death, if the fetal death occurs after a gestational period of 20 completed weeks or if the deceased's human remains weigh more than 350 grams:
1. First, middle, and last name of deceased, if applicable;

2. The deceased's sex;
3. Plurality of delivery;
4. If plurality involves more than one fetal death, the deceased's order of birth;
5. Date of delivery;
6. Hour of delivery;
7. Address where delivery occurred including street address, city or town, zip code, and county;
8. If delivery occurred:
    a. At home:
        i. Whether the delivery was planned to occur at home; and
        ii. The street address, city or town, state, and zip code of the home; or
    b. Not at home:
        i. Type of facility where delivery occurred;
        ii. Zip code where delivery occurred; and
        iii. The facility's National Provider Number;
9. Estimation of the deceased's gestational age;
10. Weight in grams of the deceased at delivery;
11. Whether:
    a. The deceased was dead at first assessment with no ongoing labor,
    b. The deceased was dead at first assessment with ongoing labor,
    c. The deceased died during labor after first assessment, or
    d. It is unknown when the deceased died;
12. The following information about the deceased's father:
    a. First, middle, and last name;
    b. Race;
    c. Whether the father is of Hispanic origin and if the father is of Hispanic origin, what type of Hispanic origin;
    d. Date of birth;
    e. State, territory, or foreign country where father was born; and
    f. Highest degree or level of education completed by the father at the time of the deceased's delivery;
13. The following information about the deceased's mother:
    a. First, middle, and last name before first marriage;
    b. Race;
    c. Whether the mother is of Hispanic origin and if the mother is of Hispanic origin, what type of Hispanic origin;
    d. Date of birth;
    e. State, territory, or foreign country where the mother was born;
    f. Street address, apartment number if applicable, city or town, state, and county of mother's usual residence;
    g. Highest degree or level of education completed by the mother at the time of the deceased's delivery;
    h. Whether the mother's usual residence is inside city limits;
    i. Date last normal menses began;
    j. Whether the mother received prenatal care;
    k. If the mother received prenatal care:
        i. Date of first prenatal care visit;
        ii. Date of last prenatal care visit; and
        iii. Total number of prenatal visits for this pregnancy;

l. Whether the prenatal record was available for completion of the fetal death report;
m. Whether the mother was married at the time of delivery;
n. The number of previous live births;
o. The number of other pregnancy outcomes not including this delivery;
p. If applicable:
    i. The date of the last live birth, and
    ii. The date of the last other pregnancy outcome;
q. Whether the mother was transferred for medical reasons before delivery;
r. If the mother was transferred, the name of the facility that the mother was transferred from;
s. Whether the mother received WIC food for herself during this pregnancy;
t. Whether any of the following occurred 24 hours before delivery or within 24 hours after delivery:
    i. Maternal transfusion,
    ii. Third or fourth degree perineal laceration,
    iii. Ruptured uterus,
    iv. Unplanned hysterectomy,
    v. Admission to intensive care unit, or
    vi. Unplanned operating room procedure following delivery;
u. Whether the mother had been diagnosed with any of the following infections during this pregnancy:
    i. Gonorrhea,
    ii. Syphilis,
    iii. Chlamydia,
    iv. Listeria,
    v. Group B streptococcus,
    vi. Cytomegalovirus,
    vii. Parvovirus, or
    viii. Toxoplasmosis,
v. Whether the mother had been diagnosed with any other infection during pregnancy and the name of the infection;
w. Risk factors present in this pregnancy;
x. Whether the mother smoked before or during pregnancy;
y. If the mother smoked before or during pregnancy, the number of cigarettes she smoked per day during:
    i. The three months before the pregnancy,
    ii. The first trimester of the pregnancy,
    iii. The second trimester of the pregnancy, and
    iv. The last trimester of the pregnancy;
z. The mother's height in inches;
aa. The mother's weight:
    i. Prepregnancy or at first prenatal visit, and
    ii. At delivery;
bb. Whether labor was induced;
cc. Whether labor was augmented;
dd. Whether there was a non-vertex presentation;
ee. Whether steroids were administered for fetal lung maturation before delivery;
ff. Whether antibiotics were administered to the mother during labor;
gg. Whether there was moderate or heavy meconium staining of the amniotic fluid;
hh. Whether an epidural or spinal anesthesia was administered to the mother during labor;

ii. A chronology of the mother's labor and delivery;
jj. Whether delivery was attempted:
i. With forceps, or
ii. Vacuum extraction;
kk. The fetal presentation at delivery;
ll. Final route and method of delivery;
mm. If a cesarean delivery, whether a trial of labor was attempted;
nn. If applicable, how many previous cesarean deliveries did the mother have; and
oo. Whether the mother had a hysterotomy or a hysterectomy;

14. Any congenital anomalies of the deceased;
15. Whether an autopsy was planned or performed;
16. Whether a histological placental examination was performed;
17. Whether autopsy or histological placental examination results were used in determining the cause of the fetal death;
18. Whether the placenta appearance was normal or abnormal;
19. A description of the fetal appearance at delivery;
20. Any cause or condition that contributed to the fetal death;
21. Any additional cause or condition of significant medical importance;
22. The name, National Provider Number, and professional credential of the individual attending the delivery;
23. The name and title of the individual completing the information;
24. The principal source of payment for the delivery;
25. The anticipated final disposition of the human remains including one or more of the following:
    a. Hospital or abortion clinic disposition,
    b. Burial,
    c. Entombment,
    d. Anatomical gift of the human remains except for donation of a part,
    e. Cremation,
    f. Removal from the state, and
    g. Other final disposition of the human remains; and
26. If an anticipated final disposition is anatomical gift except for donation of a part, another anticipated final disposition other than removal from the state; and
27. If an anticipated final disposition is removal from the state:
    a. Whether removal from the state includes removal from the United States, and
    b. Another anticipated final disposition other than anatomical gift except for donation of a part.

B. The hospital, abortion clinic, physician, or midwife responsible for submitting the information in subsection (A) to a local registrar, deputy local registrar, or the state registrar shall:

1. Maintain a copy of the evidentiary document used to collect the information for 10 years from the date on the evidentiary document, and
2. Provide a copy of the evidentiary document to the state registrar for review within 48 hours from the time of the state registrar's request.

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DEFINITIONS AND INSTRUCTIONS FOR COMPLETING THE FETAL DEATH FACILITY WORKSHEET

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DEFINITIONS	INSTRUCTIONS	SOURCE
NAME AND DELIVERY INFORMATION		
Childs First, Middle, and Last Name including Suffix–	If no name has been chosen, place an **X** in the "Not Named" check-box then enter in the Mother's maiden or legal last name in the Child's last name field. Leave the Middle name blank.	Parent(s)
Sex – the sex of the infant	Place an **X** in indicate whether the infant is male, female, or unknown	
Date of Delivery – The child's date of delivery Month, Day, Year	Use the format month, day, and four digit year as in 01/01/2013. Unknown may not be used for abortion clinics.	
Time of Delivery – The child's time of delivery hh:mm	Enter hour of delivery in AM, PM, or Military. Military time is highly encouraged.	
Plurality – The number of fetuses delivered live or dead at any time in the pregnancy regardless of gestational age, or if the fetuses were delivered at different dates in the pregnancy. "Reabsorbed" fetuses (those that are not delivered: expulsed or extracted from the mother) should not be counted **If Not Single Birth, Specify Birth Order**	Enter the number of fetuses delivered in this pregnancy. Enter the complete word for Single, Twins, Triplets, etc. Enter the complete word for First, Second, Third, etc.	
PLACE OF DELIVERY		
To return to previous location in the document – press alt+ left arrow		
Place where birth/delivery occurred/Birthplace The type of place where the birth occurred. **Hospital** **Freestanding birthing center -** No direct physical connection with an operative delivery center **Home birth** The birth occurred at a private residence. **Clinic/Doctor's office** **Abortion Clinic** **Other**	Check the box that best describes the type of place where the birth occurred. If home birth is checked, check whether the home birth was planned. If unknown whether a planned home birth write "unknown." Enter the 4 digit zip code of the abortion clinics address where the delivery occurred Specify taxi, cab, train, plane etc.	1st Admission History and Physical (H&P) *under*— General Admission *under*— □ Admitted from home, doctor's office, other *or*— □ Problem list/findings 2nd Delivery Record *under*— □ Delivery information □ Labor and delivery summary □ Maternal obstetric (OB)/labor summary *under*—delivery □ Summary of labor and delivery (L & D) 3rd Basic Admission Data 4th Progress Notes or Note
State of Delivery – Arizona	Arizona shall always be listed for the State of event. Non-Arizona events shall not be submitted for registration.	

City, town, or location of birth: The name of the city, town, township, village, or other location where the birth occurred	Enter the name of the city, town, township, village, or other location where the birth occurred. If the birth occurred in international waters or air space, enter the location where the infant was first removed from the boat or plane.	
County of birth: The name of the county where the birth occurred.	Enter the name of the county where the birth occurred. Only the County where the delivery occurred shall register the record. If the birth occurred in international waters or air space, enter the name of the county where the infant was removed from the boat or plane.	
Facility Name: the name of the facility where the delivery took place.	Enter the name of the facility where the birth occurred. If this birth did not occur in a hospital or freestanding birthing center, enter the street and number of the place where the birth occurred. If this birth occurred en route, that is, in a moving conveyance, enter the city, town, village, or location where the child was first removed from the conveyance. If the birth occurred in international air space or waters, enter "plane" or boat.	
Facility National Provider Identifier (NPI)	Enter the facility's National Provider Identification Number (NPI). If no NPI, enter the state hospital code.	NPI
ATTENDANT		
To return to previous location in the document – press alt+ left arrow		
Attendant's Name, Title, and NPI The name, title, and National Provider Identification Number (NPI) of the person responsible for delivering the child. **M.D**. (doctor of medicine) **D.O.** (doctor of osteopathy) **CNM/CM** (certified nurse midwife/certified midwife) **Other midwife** (midwife other than a CNM/CM) **Other** (specify) The attendant at birth/delivery is defined as the individual physically present at the delivery who is responsible for the delivery.	Enter the complete licensed name, title, and NPI number of the person responsible for delivering the child. Check one box to specify the attendant's title. If "other" is checked, enter the specific title of the attendant.	
NAME OF PERSON COMPLETING REPORT		
First, Middle, Last Name including Suffix	Enter the name of the person at the Abortion Clinic who completes the Fetal Death Worksheet	
Title/Office Location	Enter the title of the person at the Abortion Clinic who completes the Fetal Death	

	Worksheet	
Date Completed (mm/dd/yyyy)	Enter in the completed date the Fetal Death Worksheet was completed.	
Phone Number	Enter in an appropriate phone number, including area code, for the Abortion Clinic. This number is critical piece of communication for all parties involved.	
MOTHER'S INFORMATION		
Mother's Name Prior to First Marriage **First, Middle, and Last Name including Suffix**	Enter in the complete Mother's name prior to first marriage. This is typically her maiden name. If there is no middle name, leave it blank.	
Mother's Current Legal Name	Enter in the Mother's complete legal name. If there is no middle name, leave it blank.	
Mother's Date of Birth (mm/dd/yyyy)	Use the format month, day, and four digit year as in 01/01/1980.	
Mother's Country of Birth	Enter in the complete Country – Do not abbreviate.	
Mother's State or Territory of Birth	Enter in the complete State of Birth – Do not abbreviate.	
Mother's Education	Check the box that best describes the highest level of schooling that was completed by the mother at the time of delivery.	
MARITAL INFORMATION		
Mother Married (at delivery, conception, or anytime in between?)	Check either Yes, No, or Unknown	
Was Mother ever Married?	Check either Yes, No or Unknown if she was ever legally married.	
MOTHER'S HISPANIC ORIGIN/RACE		
Select the Item that Best Describes whether the Mother is Spanish/Hispanic/Latina	Select No, Not Spanish, Hispanic, Latina if the mother is NOT of Hispanic origin. One or more selections may be checked.	
Mother's Race	Check all that apply. If American Indian or Alaska Native, enter the primary tribe and up to 3 additional tribes by the full tribe name. *For a list of Native American tribes specific to Arizona, reference the Arizona Tribal Addendum.*	
RESIDENCE OF MOTHER		
Street Number	Enter in the complete street/ house number where the mother normally lives and sleeps at the time of delivery	
Dir. (East, West, etc)	Enter in the complete word	
Street Name	Enter in the complete street name	
Desig. (Street, Avenue, etc)	Enter in the complete name	
Quadrant	Enter in the complete name	
Residence Address Line Two	Enter in the complete apartment number or space number. A residence description may also be entered in this field.	
Zip Code	Enter in the complete ZIP code.	
Inside City Limits?	Check either Yes, No or Unknown	

Country	Enter in the Country where mother resides at the time of delivery.	
State	Enter in the State where mother resides at the time of delivery.	
County	Enter in the County where mother resides at the time of delivery	
City	Enter in the City where mother resides at the time of delivery	
Is Mother's Residence in an Arizona Tribal Community? If yes, identify the name of the Tribal Community.	Check Yes, No, or Unknown *For a list of Native American tribes specific to Arizona, reference the Arizona Tribal Addendum.*	
FATHER'S INFORMAITON		
Father's Current Legal Name	Enter in the Father's complete legal name. If there is no middle name, leave it blank.	
Father's Date of Birth (mm/dd/yyyy)	Use the format month, day, and four digit year as in 01/01/1980.	
Father's Country of Birth	Enter in the complete Country – Do not abbreviate.	
Father's State or Territory of Birth	Enter in the complete State of Birth – Do not abbreviate.	
Father's Education	Check the box that best describes the highest level of schooling that was completed by the father at the time of delivery.	
FATHER'S HISPANIC ORIGIN/RACE		
Select the Item that Best Describes whether the Father is Spanish/Hispanic/Latino	Select No, Not Spanish, Hispanic, Latino if the father is NOT of Hispanic origin. One or more selections may be checked.	
Father's Race	Check all that apply. If American Indian or Alaska Native, enter the primary tribe and up to 3 additional tribes by the full tribe name. *For a list of Native American tribes specific to Arizona, reference the Arizona Tribal Addendum.*	
PRENATAL & BIRTHING INFORMATION		
To return to previous location in the document – press alt+ left arrow		
Date last normal menses began The date the mother's last normal menstrual period began. This item is used to compute the gestational age of the infant.	Enter all known parts of the date of the mother's last normal menstrual period began. If no parts of the date are known, write in "unknown."	
Did Mother get WIC food for herself during this pregnancy?	Check Yes, No, or Unknown	WIC = Women Infants & Children
Date of first prenatal care visit The date a physician or other health care professional first examined and/or counseled the pregnant woman for the pregnancy	Enter the month, day, and year of the first prenatal care visit. Complete all parts of the date that are available. Leave the rest blank. If "no prenatal care," check the box.	1st Prenatal Care Record *under*— Intake information Initial physical exam Prenatal visits flow sheet Current pregnancy 2nd Initial Physical Examination
Date of last prenatal care visit	Enter the month, day, and year of the last	1st Prenatal Care Record *under*—

The month, day, and year of the last prenatal care visit recorded in the records.	prenatal care visit recorded in the records. **NOTE**: Enter the date of the last visit given in the most current record available. Do not estimate the date of the last visit. Complete all parts of the date that are available. Leave the rest blank.	Current Pregnancy 2nd Prenatal Visits Flow Sheets (last date shown)
Total number of prenatal care visits for this pregnancy The total number of visits recorded in the record.	Count only those visits recorded in the record. **NOTE**: Enter the total number of visits listed in the most current record available. Do not estimate additional visits when the prenatal record is not current. If none, enter "0." The "no prenatal care" box should also be checked in previous item.	Prenatal Care Record *under*— Prenatal Visit Flow Sheet (count visits)
Was the Prenatal Record Available for Completion of the Fetal Death Report?	Check Yes or No	
Weight of child in grams	Enter the weight (in grams) of the infant at birth. Do not convert pounds and ounces (lbs. and oz.) to grams. If the weight in grams is not available, enter the birth weight in lbs. and oz.	1st Delivery Record *under*— Infant Data 2nd Admission Assessment *under*—Weight
Estimate of gestation at delivery (Completed Weeks) The best obstetric estimate of the infant's gestation in completed weeks based on the birth attendant's final estimate of gestation. This estimate of gestation should be determined by all perinatal factors and assessments such as ultrasound, but not the neonatal exam. Ultrasound taken early in pregnancy is preferred.	Enter the best obstetric estimate of the infant's gestation in completed weeks. If a fraction of a week is given (e.g., 32.2 weeks) round down to the next whole week (.e.g., 32 weeks). If the obstetric estimate of gestation is not known, enter "unknown" in the space. Do not complete this item based solely on the infant's date of birth and the mother's date of last menstrual period.	1st OB Admission H&P *under*— □ Weeks □ Gestational age
Mother's Height	Mother height in feet and inches	
Mother's Pre-pregnancy Weight (In Pounds)		
Mother's Weight at Delivery The mother's weight at the time of delivery.	Enter the mother's weight at the time of delivery. Use pounds only. For example, enter 140½ pounds as 140 pounds. If the mother's delivery weight is unknown, enter "unknown."	1st Prenatal Care Record *under*— □ Menstrual history □ Nursing admission triage form 2nd Admission H&P *under*— Medical History
The Total Number of Previous Live Births	<u>Do not include this infant</u>. Include all previous live born infants who are still living. **For multiple deliveries:** Include all live born infants before this infant in the pregnancy. If the first born, do not include this infant. If the second born, include the first born, etc. **If no previous live born infants, check "none."**	1st Prenatal Care Record *under*— □ Intake information □ Gravida section – L (living) – last number in series □ Para section – L – last number in series □ Pregnancy history information □ Previous OB history □ Past pregnancy history 2nd Labor and Delivery Nursing Admission Triage Form *under*— Patient Data 3rd Admission H&P

The Total Number of Previous Live Births now Deceased	Do not include this infant. Include all previous live born infants who are no longer living. **For multiple deliveries:** Include all live born infants before this infant in the pregnancy who are now dead. If the first born, do not include this infant. If the second born, include the first born, etc. **If no previous live born infants now dead, check "none."**	1st Prenatal Care Record *under*— □ Pregnancy history information – comments, complications □ Previous OB history – comments, complications □ Past pregnancy history – comments, complications 2nd Admission H&P
Date of last Live Birth (mm/yyyy)	Refrain from providing partial dates If applicable, enter the month and year of birth of the last live-born infant. Include live-born infants now living and now dead.	
Total number of other pregnancy outcomes Includes pregnancy losses of any gestation age. Examples: spontaneous or induced losses or ectopic pregnancy.	Include all previous pregnancy losses that did not result in a live birth. **If no previous pregnancy losses, check "none."** **For multiple deliveries:** Include all previous pregnancy losses before this infant in this pregnancy and in previous pregnancies.	1st Prenatal Care Record *under*— □ Gravida section – "A" (abortion/miscarriage) □ PARA section - "A" □ Pregnancy history information - comments, complications □ Previous OB history - comments, complications □ Past pregnancy history - comments, complications 2nd Labor and Delivery Nursing Admission Triage Form 3rd Admission H&P
Date of last other pregnancy outcome The date that the last pregnancy that did not result in a live birth ended. Includes pregnancy losses at any gestational age. Examples: spontaneous or induced losses or ectopic pregnancy.	If applicable, enter the month and year.	1st Prenatal Care Record *under*— □ Pregnancy history information □ Previous OB history □ Past pregnancy history 2nd Admission H&P
CIGARETTE SMOKING BEFORE AND DURING PREGNANCY		
Answer for each time period the average number of cigarettes per day	If None, select the "Never Smoked if Lifetime" check-box and enter the number "0" in each time period field. 1 pack = 20 cigarettes	
PAYMENT INFORMATION		
Principal source of payment The principal source of payment at the time of delivery: **Private insurance** (Blue Cross/Blue Shield, Aetna, etc.) **AHCCCS** (or a comparable State program) **Self-pay** (no third party identified) **Indian Health Services (HIS)** **Other (Specify)** **Unknown**	Check the box that best describes the principal source of payment for this delivery. If "other" is checked, specify the payer. If the principal source of payment is not known, enter "unknown" in the space. This item should be completed by the facility. If the birth did not occur in a facility, it should be completed by the attendant or certifier.	
MEDICAL RISK FACTORS		
Risk factors in this pregnancy	Check all boxes that apply. The mother may	

	have more than one risk factor. If the mother has none of the risk factors, check "none of the above."	
Diabetes Glucose intolerance requiring treatment. - ***Pre-pregnancy*** Diagnosis before this pregnancy. - ***Gestational*** Diagnosis during this pregnancy.	If diabetes is present, check either pre-pregnancy or gestational diabetes. Do not check both.	1st Prenatal Care Record *under—* Medical history Previous OB history *under—* summary of previous pregnancies Problem list *or—* initial risk assessment Historical risk summary Complications of previous pregnancies Factors this pregnancy 2nd Labor and Delivery Nursing Admission Triage Form *under—* Medical complications Comments 3rd Admission H&P *under—* Current pregnancy history Medical history Previous OB history *under—* pregnancy related Problem list/findings 4th Delivery Record *under—* Maternal OB/labor summary Labor and delivery admission history Labor summary record
Hypertension Elevation of blood pressure above normal for age, gender, and physiological condition. - ***Pre-pregnancy (chronic)*** Diagnosis prior to the onset of this pregnancy-does not include gestational (pregnancy induced hypertension (PIH). - ***Gestational*** Diagnosis in this pregnancy (Pregnancy induced hypertension, preeclampsia).	If hypertension is present, check either pre-pregnancy or gestational hypertension. Do not check both.	See above
Eclampsia Hypertension with proteinuria with generalized seizures or coma. May include pathologic edema.	If eclampsia is present, one type of hypertension (either gestational or chronic) may be checked).	See above
Previous preterm births History of pregnancy(ies) terminating in a live birth of less than 37 completed weeks of gestation.		1st Prenatal Care Record *under—* Medical history Previous OB history *under—* summary of previous pregnancies Problem list *or—*initial risk assessment

		☐ Historical risk summary ☐ Complications of previous pregnancies 2nd Labor and Delivery Nursing Admission Triage Form *under*— ☐ Medical complications ☐ Comments 3rd Admission H&P *under*— ☐ Medical history ☐ Previous OB history *under*—pregnancy related ☐ Problem list/findings
Other previous poor pregnancy outcome History of pregnancies continuing into the 20th week of gestation and resulting in any of the listed outcomes: - Perinatal death (including fetal and neonatal deaths) - Small for gestational age - Intrauterine-growth-restricted birth		1st Prenatal Care Record *under*— ☐ Medical history ☐ Previous OB history *under*—summary of previous pregnancies ☐ Problem list *or*—initial risk assessment ☐ Historical risk summary ☐ Complications of previous pregnancies 2nd Labor and Delivery Nursing Admission Triage Form *under*—Comments 3rd Admission H&P *under*— ☐ Previous OB history *under*—pregnancy related ☐ Complications Previous Pregnancies ☐ Problem list/findings
Mother had a previous cesarean delivery Previous delivery by extracting the fetus, placenta, and membranes through an incision in the mother's abdominal and uterine walls. **If yes, how many?_____**	If the mother has had a previous cesarean delivery, indicate the number of previous cesarean deliveries she has had.	1st Prenatal Care Record *under*— ☐ Past pregnancy history ☐ Past OB history ☐ Problem list *or*—initial risk assessment 2nd Labor and Delivery Nursing Admission Triage Form *under*—Comments 3rd Admission H&P *under*— ☐ Past OB history ☐ Past pregnancy history *under*—problem list/findings
❖ **INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY** Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive	Check all boxes that apply. The mother may have more than one infection. If the mother has none of the risk factors, check "none of the above."	See Below

diagnosis is not present in the available record.		
Gonorrhea A positive test/culture for *Neisseria gonorrhoeae*		1st Prenatal Record *under*— □ Infection history □ Sexually transmitted diseases □ Problem list □ Complications this pregnancy □ Factors this pregnancy □ Medical history 2nd Labor and Delivery Nursing Admission Triage Form *under*— Comments 3rd Admission H&P *under*— □ Current pregnancy history □ Medical history □ Problem list/findings 4th Delivery Record *under*— □ Maternal OB/labor summary □ Labor and delivery admission history
Syphilis A positive test for *Treponema pallidum*		See Gonorrhea
Chlamydia A positive test for Chlamydia trachomatis		See Gonorrhea
***Listeria** Listeria monocytogenes. * *Applicable to fetal deaths only.*		See Gonorrhea
***Group B Streptococcus** A diagnosis of or positive test for Streptococcus agalactiae or group B streptococcus. * *Applicable to fetal deaths only.*		See Gonorrhea
***Cytomeglovirus** A diagnosis of or positive test for Cytomegalovirus. * *Applicable to fetal deaths only.*		See Gonorrhea
***Parvovirus** A diagnosis of or positive test for Parvovirus B19. * *Applicable to fetal deaths only.*		See Gonorrhea
***Toxoplasmosis** A diagnosis of or positive test for Toxoplasma gondii. * *Applicable to fetal deaths only.*		See Gonorrhea
LABOR AND DELIVERY		
❖ **MATERNAL MORBIDITY** - Serious complications experienced by the mother associated with labor and delivery	Check all boxes that apply. If the mother has none of the complications, check "none of the above."	See Below
➢ **Maternal transfusion** - Includes infusion of whole blood or packed red blood cells associated with labor		1st Delivery Record *under*— □ Labor summary □ Delivery summary

and delivery		2nd Physician Delivery Notes/Operative Notes 3rd Intake & Output Form
➢ **Third or fourth degree perineal laceration** - 3° laceration extends completely through the perineal skin, vaginal mucosa, perineal body, and anal sphincter. - 4° laceration is all of the above with extension through the rectal mucosa.		1st Delivery Record *under*— Episiotomy section Lacerations section 2nd Recovery Room Record *under*— Maternal Data – Delivered
➢ **Ruptured uterus** - Tearing of the uterine wall.		1st Delivery Record *under*— Delivery Summary Note – Comments/Complications 2nd Operative Note 3rd Physician Progress Note
➢ **Unplanned hysterectomy** - Surgical removal of the uterus that was not planned before the admission. Includes an anticipated, but not definitively planned, hysterectomy		*Same as* ruptured uterus *above*
➢ **Admission to an intensive care unit** - Any admission, planned or unplanned, of the mother to a facility or unit designated as providing intensive care		1st Physician Progress Note 2nd Transfer Note
➢ **Unplanned operating room procedure following delivery** - Any transfer of the mother back to a surgical area for an operative procedure that was not planned before the admission for delivery. - Excludes postpartum tubal ligations.		1st Physician Operative Note 2nd Physician Progress Note 3rd Physician Ord
❖ **CHARACTERISTICS OF LABOR AND DELIVERY**		
➢ **Precipitous labor -** Less than 3 hours.	If precipitous labor is indicated check that labor lasted less than 3 hours.	1st Labor & Delivery Record *under*— Labor summary – total length of labor Labor chronology – total length of labor 2nd Delivery Comments
➢ **Prolonged labor -** Greater than or equal to 20 hours	If prolonged labor is indicated check that labor lasted 20 or more hours	Same as precipitous labor above
➢ **Induction of labor** - Initiation of uterine contractions by medical and/or surgical means for the purpose of delivery before the	Check this item if medication was given or procedures to induce labor were performed BEFORE labor began	1st Delivery Record *under*— Maternal OB/labor summary Labor and delivery admission history Labor summary record

spontaneous onset of labor (i.e., before labor has begun).		2nd Physician Progress Note 3rd Labor and Delivery Nursing Admission Triage Form
➢ **Augmentation of labor** - Stimulation of uterine contractions by drug or manipulative technique with the intent to reduce the time of delivery (i.e., after labor has begun).	Check this item if medication was given or procedures to augment labor were performed AFTER labor began	*Same* as 1st and 2nd sources for induction of labor *above*.
➢ **Steroids (glucocorticoids**) for fetal lung maturation received by the mother before delivery. - Includes: betamethasone, dexamethasone, or hydrocortisone specifically given to accelerate fetal lung maturation in anticipation of preterm delivery. - Does not include steroid medication given to the mother as an anti-inflammatory treatment before or after delivery.	Medications given before the delivery	
➢ **Moderate or heavy meconium staining of the amniotic fluid** - Staining of the amniotic fluid caused by passage of fetal bowel contents during labor and/or at delivery that is more than enough to cause a greenish color change of an otherwise clear fluid.		1st Delivery Record *under*— □ Maternal OB/labor summary – comments/complications □ Labor summary record – comments/complications □ Amniotic fluid summary section – comments, color □ Time membranes ruptured section 2nd Newborn Admission H&P 3rd Physician Progress Note
➢ **Epidural or spinal anesthesia during labor** - Administration to the mother of a regional anesthetic to control the pain of labor. - Delivery of the agent into a limited space with the distribution of the analgesic effect limited to the lower body.		1st Delivery Record *under*— □ Maternal OB labor summary *under*— analgesia/anesthesia □ Labor summary record *under*— analgesia/anesthesia
❖ **MOTHER TRANSFERRED - Was the mother transferred to this facility for maternal medical or fetal indications for delivery?** - Transfers include hospital to hospital, birth facility to hospital, etc. Does not include home to hospital.	If the mother was transferred from another facility check "yes." If "yes," enter the name of the facility the mother transferred from. If the name of the facility is not known, enter "unknown." Check "no" if the mother was transferred from home.	1st Labor & Delivery Nursing Admission Triage Form *under*— □ Reason for admission □ Comments 2nd Admission H&P 3rd Labor & Delivery – Delivery Record □ Maternal OB/labor summary □ Labor and delivery admission

		history □ Labor summary record
CONGENITAL ANOMALIES OF CHILD		
Congenital anomalies of the newborn Malformations of the newborn diagnosed prenatally or after delivery.	Check all boxes that apply	
Anencephaly Partial or complete absence of the brain and skull. Also called anencephalus, acrania, or absent brain. Also includes infants with craniorachischisis (anencephaly with a contiguous spine defect)		1st Labor and Delivery Summary Record *under*—Infant Data 2nd Newborn Admission H&P
Meningomyelocele/Spina bifida Spina bifida is herniation of the meninges and/or spinal cord tissue through a bony defect of spine closure. Meningomyelocele is herniation of meninges and spinal cord tissue. Meningocele (herniation of meninges without spinal cord tissue) should also be included in this category. Both open and closed (covered with skin) lesions should be included. Do not include Spina bifida occulta (a midline bony spinal defect without protrusion of the spinal cord or meninges).		*Same as* anencephaly
Cyanotic congenital heart disease Congenital heart defects that cause cyanosis.		1st Physician Progress Notes *under*— □ Circulation □ Cardiovascular
Congenital diaphragmatic hernia Defect in the formation of the diaphragm allowing herniation of abdominal organs into the thoracic cavity		1st Infant H&P 2nd Labor and Delivery Summary Record *under*—Infant Data
Omphalocele A defect in the anterior abdominal wall, accompanied by herniation of some abdominal organs through a widened umbilical ring into the umbilical stalk. The defect is covered by a membrane (different from gastroschisis [see below]), although this sac may rupture. Also called exomphalos. Do not include umbilical hernia (completely covered by skin) in this category. Do not include Spina bifida occulta (a midline bony spinal defect without protrusion of the spinal cord or meninges).		1st Labor and Delivery Summary Record *under*—Infant Data 2nd Admission H&P *under*—G.I.
Gastroschisis An abnormality of the anterior abdominal wall, lateral to the umbilicus, resulting in herniation of the abdominal contents directly into the amniotic cavity. Differentiated from omphalocele by the location of the defect and the absence of a		*Same as* Omphalocele

protective membrane		
Limb reduction defect—excluding congenital amputation and dwarfing syndromes Complete or partial absence of a portion of an extremity, secondary to failure to develop.		1st Labor and Delivery Summary Record *under*—Infant Data 2nd Newborn H&P
Cleft lip with or without cleft palate Incomplete closure of the lip. May be unilateral, bilateral, or median.		*Same as* limb reduction defect
Cleft palate alone Incomplete fusion of the palatal shelves. May be limited to the soft palate or may extend into the hard palate. Cleft palate in the presence of cleft lip should be included in the category above.		*Same as* limb reduction defect
Down syndrome Trisomy 21	Check if a diagnosis of Down syndrome, Trisomy 21 is confirmed or pending	1st Infant Progress Notes 2nd Genetic Consult.
Suspected chromosomal disorder Includes any constellation of congenital malformations resulting from or compatible with known syndromes caused by detectable defects in chromosome structure.	Check if a diagnosis of a suspected chromosomal disorder is confirmed or pending. (May include Trisomy 21.)	*Same as* Down syndrome
Hypospadias Incomplete closure of the male urethra resulting in the urethral meatus opening on the ventral surface of the penis. Includes: First degree (on the glans ventral to the tip) - Second degree (in the coronal sulcus) - Third degree (on the penile shaft)		1st Labor & Delivery Summary *under*—Infant Data 2nd Newborn H&P *under*—Genitourinary (GU)
OBSTETRIC PROCEDURES		
OBSTETRIC PROCEDURES - Medical treatment or invasive/manipulative procedure performed during this pregnancy to treat the pregnancy or to manage labor and/or delivery.	Check all boxes that apply. The mother may have more than one procedure. If the mother has none of the procedures, check "none of the above."	**See below**
Cervical cerclage - Circumferential banding or suture of the cervix to prevent or treat passive dilation. Includes: MacDonald's suture, Shirodkar procedure, abdominal cerclage via laparotomy		1st Prenatal Record *under*— □ Medical history □ Problem list *or*— initial risk assessment □ Historical risk summary □ Complications this pregnancy □ Factors this pregnancy 2nd Labor and Delivery Nursing Admission Triage Form *under*— □ Complications □ Comments 3rd Admission H&P *under*— □ Current pregnancy history □ Medical history □ Problem list/findings 4th Delivery Record *under*—

		☐ Maternal OB ☐ Labor and delivery admission history
Tocolysis Administration of any agent with the intent to inhibit preterm uterine contractions to extend the length of the pregnancy. Medications: - Magnesium sulfate (for preterm labor) - Terbutaline - Indocin (for preterm labor)	Check all boxes that apply. The mother may have more than one procedure. If the mother has none of the procedures, check "none of the above."	1st Prenatal Care Record *under*— ☐ Medical history ☐ Problem list *or*— initial risk assessment ☐ Historical risk summary ☐ Complications of previous pregnancies ☐ Factors this pregnancy 2nd Labor and Delivery Nursing Admission Triage Form *under*— ☐ Complications this pregnancy ☐ Medications ☐ Comments 3rd Admission H&P *under*— ☐ Current pregnancy history ☐ Medication ☐ Medical history ☐ Problem list/findings 4th Delivery Record *under*— ☐ Maternal OB/labor summary ☐ Labor and delivery admission history ☐ Labor summary record
External cephalic version Attempted conversion of a fetus from a nonvertex to a vertex presentation by external manipulation. ***Successful*** Fetus was converted to a vertex presentation. ***Failed*** Fetus was not converted to a vertex presentation.	If checked, also indicate whether the procedure was a success or a failure.	1st Prenatal Care Record *under*— ☐ Problem list ☐ Historical risk summary ☐ Complications this pregnancy ☐ Factors this pregnancy 2nd Labor and Delivery Nursing Admission Triage Form *under*— ☐ Complications ☐ Comments 3rd Admission H&P *under*— ☐ Current pregnancy history ☐ Medical history ☐ Problem list/findings 4th Delivery Record *under*— ☐ Maternal OB/labor summary ☐ Labor and delivery admission history ☐ Labor summary record
METHOD OF DELIVERY		
Method of Delivery – The physical process by which the complete delivery of the fetus was affected.		
Was Delivery with Forceps Attempted, but	Check either Yes, No or Unknown	

Unsuccessful?		
Fetal presentation at Delivery - ***Cephalic*** – presenting part of the fetus listed as vertex, occiput anterior (OA), occiput posterior (OP). - ***Breech*** – presenting part of the fetus listed as breech, complete breech, frank breech, footling breech. - ***Other –*** any other presentation not listed above. - ***Unknown***	Check one of the four boxes.	1st Delivery Record *under*— Fetal Birth Presentation
Was Delivery with Vacuum Extraction Attempted, but Unsuccessful?	Check either Yes, No or Unknown	
Final Route and Method of Delivery - ***Vaginal/spontaneous*** Delivery of the entire fetus through the vagina by the natural force of labor with or without manual assistance from the delivery attendant. - ***Vaginal/forceps*** Delivery of the fetal head through the vagina by the application of obstetrical forceps to the fetal head. - ***Vaginal/vacuum*** Delivery of the fetal head through the vagina by the application of a vacuum cup or ventouse to the fetal head. - ***Cesarean*** Extraction of the fetus, placenta, and membranes through an incision in the maternal abdominal and uterine walls **Unknown**	Check one of the boxes.	1st Delivery Record *under*— Method of Delivery 2nd Newborn Admission H&P 3rd Recovery Room Record *under*— Maternal Data – Delivered
If cesarean, was a trial of labor attempted? Labor was allowed, augmented, or induced with plans for a vaginal delivery.	Check either Yes, No, or Unknown	
****Hysterotomy/Hysterectomy*** ***Hysterotomy*** The incision into the uterus extending into the uterine cavity. May be performed vaginally or transabdominally. ***Hysterectomy*** The surgical removal of the uterus. May be performed abdominally or vaginally. * Applicable to fetal deaths only.	Check either Yes, No, or Unknown	
FETAL AND PLACENTA APPEARANCE		
Placenta Appearance **Normal Placenta Appearance** **Abnormal Placenta Appearance (Specify)**	Unknown Placenta Appearance was inserted to accommodate Abortion Clinic facilities	

Unknown Placenta Appearance		
Fetal Appearance at Delivery **Fetus Structure and Appearance Normal** **Obvious Dysmorphic Features** **Unknown Fetal Appearance at Delivery**	Unknown Fetal Appearance at Delivery was inserted to accommodate Abortion Clinic facilities	
CAUSE/CONDITIONS CONTRIBUTING TO FETAL DEATH		
Initiating Cause or Conditions & Other Significant Causes or Conditions (Select as many as apply)	Abortion Clinics – Please select the "Elective Abortion" option for the Initiating Cause. In this case, do not select the "Elective Abortion" option for the Other Significant Causes or Conditions. If applicable, Select an non- elective abortion option for the Initiating Cause or Conditions and when appropriate, select the "Elective Abortion" option for the Other Significant Causes or Conditions. Do not select Elective Abortion in both sections. Do not abbreviate Causes or Conditions – even if medical terms.	
Estimated Time of Fetal Death	Select Unknown Time of Fetal Death	
Was an Autopsy Performed?	Check either Yes, No, or Planned	Autopsies must be performed by a licensed forensic pathologist.
Was a Histological Placental Examination Performed?	Check either Yes, No, or Planned	Histological placenta examinations must be performed by a licensed forensic pathologist.
Were Autopsy or Histological Placental Examination Results used in Determining the Cause of Fetal Death?	Check Yes or No	
CERTIFICATION REVIEW – HOSPITALS, BIRTHING CENTERS, MIDWIVES, AND ABORTION CLINICS DO NOT COMPLETE THIS SECTION – MEDICAL EXAMINER USE ONLY		
DISPOSITION INFORMATION – HOSPITALS, BIRTHING CENTERS, MIDWIVES, AND ABORTION CLINICS DO NOT COMPLETE THIS SECTION – FUNERAL HOME USE ONLY		
FUNERAL FACILITY INFORMATION – HOSPITALS, BIRTHING CENTERS, MIDWIVES, AND ABORTION CLINCS DO NOT COMPLETE THIS SECTION – FUNERAL HOME USE ONLY		
NAME OF INFORMANT		
First, Middle and Last Name of the Informant	The informant is the person providing the parent's demographic and other personal information on the Fetal Death Worksheet. Typically, it is the mother providing such information.	It is **highly recommended** the Abortion Clinic retrieve the Mother's name and signature for the Informant section.
Signature of Informant and Date	Informants Signature and date	It is **highly recommended** the Abortion Clinic retrieve the Mother's name and signature for the Informant section.

HUMAN REMAINS RELEASE FORM

FACILITY NAME:		FACILITY ADDRESS:		
DECEASED PERSON'S NAME:		DATE OF BIRTH:	SEX:	SOC. SEC. # OR PT. ID #:
DATE OF DEATH:	TIME OF DEATH:	**PHYSICIAN OR NURSE PRACTITIONER EXPECTED TO SIGN MEDICAL CERTIFICATION OF DEATH:**		
		Name:		Phone #:

PERSON AUTHORIZING RELEASE TO FUNERAL ESTABLISHMENT OR RESPONSIBLE PERSON:		
Name:	Phone #:	Relationship to deceased person:

THE HUMAN REMAINS OF A PERSON WHO DIES UNDER ANY OF THE FOLLOWING CIRCUMSTANCES AS LISTED IN A.R.S. § 11-593(A) ARE REQUIRED TO BE REFERRED TO THE MEDICAL EXAMINER.

Did this person: (Check all that apply)

☐ Die while not under the care of a physician or nurse practitioner for a potentially fatal illness
☐ Die and the attending physician or nurse practitioner is not available to sign the death certificate
☐ Die as a result of violence
☐ Die suddenly when in apparent good health
☐ Die in a prison
☐ Die while a prisoner
☐ Die in a suspicious, unusual or unnatural manner
☐ Die from a disease or an accident that may be related to the person's occupation or employment
☐ Die and may present a public health hazard
☐ Die during an anesthetic or surgical procedure
☐ NONE OF THE ABOVE

WERE THE DECEASED PERSON'S HUMAN REMAINS REFERRED TO THE MEDICAL EXAMINER AS REQUIRED IN A.R.S. § 11-593?
YES ☐ NO ☐ N/A ☐ ME ACCEPTED ☐ ME RELEASED ☐ ME REFUSED ☐

THE MOST RECENT DIAGNOSIS IN THE PERSON'S MEDICAL RECORD IS:

Provide the following information if the deceased person's human remains are being released to: (1) A funeral establishment, (2) A person authorized under A.R.S. § 36-664 to receive the deceased person's communicable disease related information.

Indicate whether the deceased person had been diagnosed with or was suspected of having any of the following, as stated in the deceased persons medical record at the time of death. Please check all that apply:

☐ Infectious tuberculosis ☐ Creutzfeldt-Jakob disease ☐ Hepatitis C ☐ Other _____
☐ Human immunodeficiency virus ☐ Hepatitis B ☐ Rabies ☐ NONE

* For a death that occurs in a hospital: If the deceased individual's human remains have been accepted for donation by an organ procurement organization under A.R.S. Title 36, Chapter 7, Article 3, and the person authorized in A.R.S. §36-843 has not made or refused to make an anatomical gift, indicate whether the organ procurement organization has been notified that the deceased individual's human remains are being removed from the hospital. YES ☐ NO ☐

PERSON REPRESENTING THE HOSPITAL, NURSING CARE INSTITUTION, OR HOSPICE INPATIENT FACILITY WHO RELEASED THE HUMAN REMAINS		
Name (please print):	Signature:	Date:
PERSON ACCEPTING THE HUMAN REMAINS		
Name (please print):	Signature:	Date & Time:
FETAL DEATH INFORMATION		
Name of the Mother (please print):	Date of Delivery:	Estimated Gestational age or weight, if unknown:

* This item is not required for nursing or in-patient hospice facilities.

Report of Fetal Death Worksheet

We are truly sorry about the loss you have experienced. We understand that this is a difficult time for you and your loved ones. We need to ask you a few questions to assist in the completion of the official report of fetal death. State laws provide protection against the unauthorized release of identifying information from the report of fetal death to ensure confidentiality of the parents. This information may also help researchers understand some of the factors that are related to miscarriage and stillbirth. Your assistance in providing complete and accurate information is very important. We appreciate your help, especially during this very difficult time.

PLEASE PRINT CLEARLY

Please note: If delivery occurred in a hospital, nursing care institution, or hospice inpatient facility, the Human Remains Release Form (HRRF) must be completed (reference ARS 36-326 and AAC R9-19-301."

Name of Child-- This is optional. ☐ Not Named

_____ _____ _____ _____
Child's First Name Middle Name Last Name Suffix (Jr., II, etc.)

Child's Sex ☐Male ☐Female ☐Unknown

Date of Delivery (mm/dd/yyyy) _____ Time of Delivery (hh:mm)_____ (circle one: AM, PM, Military)

Plurality – Specify Single, Twins, Triplets, etc. _____

If Not Single Birth, Specify Birth Order (First, Second, Third, etc.) _____

Zip Code of Delivery _____ State of Delivery: **ARIZONA** County of Delivery _____

City, Town or Location of Delivery _____

Place of Delivery

☐Hospital ☐Free-Standing Birth Center
☐Home Delivery, Intended ☐ Home Delivery, Unintended ☐Home Delivery, Unknown if Intended
☐Clinic/Doctor's Office ☐Enroute ☐Other (Specify)_____
☐Unknown

Name of Delivery Facility or Specify Location, Street and Number_____
_____
Facility NPI _____

Attendant Information

Attendant Name _____ Attendant NPI_____ ☐ None ☐ Unknown

Attendant's Title
☐M.D.
☐D.O.
☐C.N.M./C.M.
☐Midwife.
☐Nurse Midwife
☐Neonatal Nurse Practitioner (NNP)
☐Physician's Assistant (PA)
☐Registered Nurse (RN)
☐Student Nurse Midwife (SNM)
☐Other Midwife
☐Other (Specify) _____

Name of Person Completing Report

_____ _____ _____ _____
First Name Middle Name Last Name Suffix (Jr., II, etc.)

_____ _____
Title/Office Location (Not for hospital use) Date Completed (mm/dd/yyyy)

Phone Number_____

Mother's Name_____ Medical Record Number_____

Revision Date: 12/20/12

Mother's Information

Mother's Name Prior to First Marriage

First Name	Middle Name	Last Name	Suffix (Jr., II, etc.)

Mother's Current Legal Name

First Name	Middle Name	Last Name	Suffix (Jr., II, etc.)

Mother's Date of Birth (mm/dd/yyyy) _____

Mother's Country of Birth _____

Mother's State of Birth _____

Select the Item that Best Describes the Highest Degree or Level of School Completed at Time of Delivery

☐8th grade or less or None
☐9th-12th grade; no diploma
☐High school graduate or GED completed
☐Some college credit, but not a degree
☐Associate degree (e.g. AA, AS)
☐Bachelor's degree (e.g. BA, AB, BS)
☐Master's degree (e.g. MA, MS, MEng, MEd, MSW, MBA)
☐Doctorate (e.g. PhD, EdD) or Professional degree (e.g. MD, DDS, DVM, LLB, JD)
☐Unknown
☐Unknown due to mother has left the facility

Marital Information

Mother Married (at delivery, conception, or anytime in between)? ☐Yes ☐No ☐Unknown
Was the mother ever married? ☐Yes ☐No ☐Unknown

Select the Item that Best Describes whether the Mother is Spanish/Hispanic/Latina; Select "No" if the Mother is not Spanish/Hispanic/Latina.

☐No, Not Spanish, Hispanic, Latina
☐Yes, Mexican, Mexican-American, Chicana
☐Yes, Puerto Rican
☐Yes, Cuban
☐Yes, Other Spanish/Hispanic/Latina (e.g. Spaniard, Salvadoran, Columbian), Specify _____
☐Unknown

Mother's Race (Check All that Apply)

☐White
☐Black or African American
☐American Indian or Alaska Native *(For a list of Native American tribes specific to Arizona, reference the Arizona Tribal Addendum)*
Enrolled or Principal Tribe_____
Additional Tribe_____
☐Asian Indian
☐Chinese
☐Filipino
☐Korean
☐Japanese
☐Vietnamese
☐Other Asian (Specify) _____ _____
☐Native Hawaiian
☐Guamanian or Chamorro

Mother's Race *(continued)*

☐Samoan
☐Other Pacific Islander (Specify) _____ _____
☐Other (Specify) _____ _____
☐Unknown

Residence of Mother

_____ _____ _____ _____ _____
Street # Dir. (East, West, etc.) Street Name Desig. (Street, Avenue, etc.) Quadrant

_____
Residence Address Line Two (Apartment number, etc.)

_____
Zip Code of Residence Inside City Limits? ☐Yes ☐No ☐Unknown

Country _____

State _____

County _____

City _____

Is Mother's Residence in an Arizona Tribal Community? ☐Yes ☐No ☐Unknown
If yes, identify the name of the tribal community_____

Father's Information

Father's Current Legal Name

_____ _____ _____ _____
First Name Middle Name Last Name Suffix (Jr., II, etc.)

Father's Date of Birth (mm/dd/yyyy) _____

Father's Country of Birth _____

Father's State of Birth _____

Select the Item that Best Describes the Highest Degree or Level of School Completed at the Time of Delivery

☐8th grade or less or None
☐9th-12th grade; no diploma
☐High school graduate or GED completed
☐Some college credit, but not a degree
☐Associate degree (e.g. AA, AS)
☐Bachelor's degree (e.g. BA, AB, BS)
☐Master's degree (e.g. MA, MS, MEng, MEd, MSW, MBA
☐Doctorate (e.g. PhD, EdD) or Professional degree (e.g. MD, DDS, DVM, LLB, JD
☐Unknown

Select the Item that Best Describes whether the Father is Spanish/Hispanic/Latino; Select "No" if the Father is not Spanish/Hispanic/Latino

☐No, Not Spanish, Hispanic or Latino
☐Yes, Mexican, Mexican-American, Chicano
☐Yes, Puerto Rican

Mother's Name_____ Medical Record Number_____

Father's Hispanic Origin *(continued)*

☐Yes, Cuban
☐Yes, Other Spanish/Hispanic/Latino (e.g. Spaniard, Salvadoran, Columbian), specify _____
☐Unknown

Father's Race (Check All that Apply)

☐White
☐Black or African American
☐American Indian or Alaska Native *(For a list of Native American tribes specific to Arizona, reference the Arizona Tribal Addendum)*
Enrolled or Principal Tribe_____
Additional Tribe_____
☐Asian Indian
☐Chinese
☐Filipino
☐Korean
☐Japanese
☐Vietnamese
☐Other Asian (Specify) _____ _____
☐Native Hawaiian
☐Guamanian or Chamorro
☐Samoan
☐Other Pacific Islander (Specify) _____ _____
☐Other (Specify) _____ _____
☐Unknown

Prenatal and Birthing Information

Date Mother's Last Normal Menses Began (mm/dd/yyyy) _____

Did Mother get WIC food for herself during this pregnancy? ☐Yes ☐No ☐Unknown

Date of First Prenatal Visit (mm/dd/yyyy) _____ ☐No Prenatal Care

Date of Last Prenatal Visit (mm/dd/yyyy) _____

Total Number of Prenatal Visits for this Pregnancy; If None, Enter "0" _____

Was the Prenatal Record Available for Completion of the Fetal Death Report? ☐Yes ☐No

Weight of Child (in Grams) _____ Obstetric Estimate of Gestation at Delivery (Completed Weeks) _____

Mother's Height _____(feet) _____(inches)

Mother's Prepregnancy Weight (in Pounds) _____ Mother's Weight at Delivery (In Pounds)_____

Number of Previous Live Births _____ (if none, enter "0")
Now Living_____ Now Dead_____
Date of Last Live Birth (mm/yyyy)_____

Number of Other Pregnancy Outcomes (Spontaneous or Induced Losses or Ectopic Pregnancies) (Do Not Include This Fetus, if none, enter "0")_____
Date of Last Other Pregnancy Outcome (mm/yyyy)_____

Cigarette Smoking Before and During Pregnancy

Answer for each time period the average number of cigarettes per day (If none, enter "0" 1 pack = 20 cigarettes)

☐Never Smoked in Lifetime

	Number of Cigarettes per Day
Three Months Before Pregnancy	_____
First Three Months of Pregnancy	_____
Second Three Months of Pregnancy	_____
Last Trimester of Pregnancy	_____

☐Unknown for all

Principal Source of Payment

☐Private Insurance
☐AHCCCS
☐Self-Pay
☐Indian Health Services (IHS)
☐Other (Specify) _____
☐Unknown

Medical Risk Factors in This Pregnancy (Check all that apply)

Yes	No	Unknown	
Diabetes			
☐	☐	☐	Prepregnancy (Diagnosis Prior to this Pregnancy
☐	☐	☐	Gestational (Diagnosis in this Pregnancy)
Hypertension			
☐	☐	☐	Prepregnancy (Chronic)
☐	☐	☐	Gestational (PiH, Preeclampsia)
☐	☐	☐	Eclampsia

Pregnancy Resulted From Infertility Treatment

☐ ☐ ☐ Pregnancy Resulted from Infertility Treatment – If Yes, Check All that Apply
- ☐ Fertility-Enhancing Drugs /Artificial Insemination or Intrauterine Insemination
- ☐ Assisted Reproductive Technology (e.g., in vitro Fertilization (IVF), gamete intrafallopian transfer (GIFT))

☐ ☐ ☐ Mother had a previous cesarean delivery – If Yes, How Many? _____
☐ ☐ ☐ Autoimmune Disorder
☐ ☐ ☐ Hemoglobinopathy
☐ ☐ ☐ Uterine Anomaly
☐ ☐ ☐ Blood Antigen Isoimmunization
☐ ☐ ☐ Motor Vehicle Accident
☐ ☐ ☐ Other Traumatic Injury
☐ ☐ ☐ Acute Drug Effect/Toxicity/Reaction
☐ ☐ ☐ Prior Incision of the Uterine Wall

Medical Risk Factors for This Pregnancy (*continued*)

Previous Adverse Pregnancy

☐	☐	☐	Previous Preterm Birth
☐	☐	☐	Fetal Death Prior to 20 Weeks
☐	☐	☐	Fetal Death at 20 Weeks or More
☐	☐	☐	Fetus/Infant with Congenital Anomaly
☐	☐	☐	Neonatal Death
☐	☐	☐	Other Previous Poor Pregnancy Outcome (Includes Perinatal Death, Small for Gestational Age/ Intrauterine Growth Restricted Birth)
☐	☐	☐	Other (Specify) _____
☐	None of the Above		

Infections Present and/or Treated During This Pregnancy

Yes	No	Unknown	
☐	☐	☐	Gonorrhea
☐	☐	☐	Syphilis
☐	☐	☐	Chlamydia
☐	☐	☐	Listeria
☐	☐	☐	Group B Streptococcus
☐	☐	☐	Cytomegalovirus
☐	☐	☐	Parvovirus
☐	☐	☐	Toxoplasmosis
☐	☐	☐	Other (Specify) _____
☐	None of the Above		

Maternal Morbidity

Yes	No	Unknown	
☐	☐	☐	Maternal Transfusion
☐	☐	☐	Third or Fourth Degree Perineal Laceration
☐	☐	☐	Ruptured Uterus
☐	☐	☐	Unplanned Hysterectomy
☐	☐	☐	Admission to Intensive Care Unit
☐	☐	☐	Unplanned Operating Room Procedure Following Delivery
☐	None of the Above		

Characteristics of Labor and Delivery

Yes	No	Unknown	
☐	☐	☐	Induction of Labor
☐	☐	☐	No Augmentation of Labor
☐	☐	☐	Non-Vertex Presentation
☐	☐	☐	Antibiotics Received by Mother During Labor
☐	☐	☐	Moderate/Heavy Meconium Staining of the Amniotic Fluid
☐	☐	☐	Epidural or Spinal Anesthesia During Labor
☐	☐	☐	Steroids (glucocorticoids) for Fetal Lung Maturation Received by the Mother Prior to Delivery

Was Mother Transferred for Maternal Medical or Fetal Indications for Delivery?

☐Yes ☐No

If Yes, Name of Facility Mother Transferred From _____

Enter Facility Address _____

Mother's Name_____ Medical Record Number_____

Congenital Anomalies of Child

Yes	No	Unknown	
☐	☐	☐	Anencephaly
☐	☐	☐	Congenital Diaphragmatic Hernia
☐	☐	☐	Meningomyelocele/Spina Bifida
☐	☐	☐	Omphalocele
☐	☐	☐	Cyanotic Congenital Heart Disease
☐	☐	☐	Gastroschisis
☐	☐	☐	Limb Reduction Defect (Excluding Congenital Amputation and Dwarfing Syndromes)
☐	☐	☐	Cleft Lip with or without Cleft Palate
☐	☐	☐	Cleft Palate Alone
☐	☐	☐	Hypospadias
☐	☐	☐	Congenital Heart Disease/Defect
☐	☐	☐	Anterior Abdominal Wall Defect
☐	☐	☐	Down Syndrome
			☐Karyotype Confirmed ☐Yes ☐No
			☐Karyotype Pending ☐Yes ☐No
☐	☐	☐	Suspected Chromosomal Disorder
			☐Karyotype Confirmed ☐Yes ☐No
			☐Karyotype Pending ☐Yes ☐No

☐ Other (Specify) _____

☐ None of the Anomalies Listed Above

Obstetric Procedures

Yes	No	Unknown	
☐	☐	☐	Cervical Cerclage
☐	☐	☐	Tocolysis
☐	☐	☐	External Cephalic Version
			☐Successful ☐Failed

☐ None of the Above

Method of Delivery

Was Delivery With Forceps Attempted, But Unsuccessful? ☐Yes ☐No ☐Unknown

Fetal Presentation at Delivery ☐Cephalic ☐Breech ☐Other ☐Unknown

Was Delivery with Vacuum Extraction Attempted, But Unsuccessful? ☐Yes ☐No ☐Unknown

Final Route and Method of Delivery – (Check One)

☐ Vaginal/Spontaneous
☐ Vaginal/Forceps
☐ Vaginal/Vacuum
☐ Cesarean
If cesarean, was a trial of labor attempted? ☐Yes ☐No ☐Unknown
☐ Unknown

☐Hysterotomy or Hysterectomy ☐Yes ☐No ☐Unknown

Fetal and Placenta Appearance

Placenta Appearance

☐ Normal Placenta Appearance
☐ Abnormal Placenta Appearance (Specify) _____

Fetal Appearance at Delivery

☐ Fetus Structure and Appearance Normal
☐ Obvious Dysmorphic Features

Yes	No	Unknown	
☐	☐	☐	Minimal to Mild Desquamation/Maceration
☐	☐	☐	Moderate to Severe Desquamation/Maceration
☐	☐	☐	Hydrops Fetalis
☐	☐	☐	Mummification

Cause/Conditions Contributing to Fetal Death

Initiating Cause or Conditions
Among the choices below, please select **the one** which most likely began the sequence of events resulting in the death of the fetus.

☐ Complications of Placenta, Cord, or Membrane: Rupture of Membranes Prior to Onset of Labor
☐ Complications of Placenta, Cord, or Membrane: Abruptio Placenta
☐ Complications of Placenta, Cord, or Membrane: Placental Insufficiency
☐ Complications of Placenta, Cord, or Membrane: Prolapsed Cord
☐ Complications of Placenta, Cord, or Membrane: Chorioamnionitis
☐ Complications of Placenta, Cord, or Membrane: True Knot in Cord
☐ Complications of Placenta, Cord, or Membrane: Other (Specify)_____
☐ Maternal Conditions/Diseases (Specify)_____
☐ Other Obstetrical or Pregnancy Complications (Specify)_____
☐ Fetal Anomaly (Specify)_____
☐ Fetal Injury (Specify) _____
☐ Fetal Infection (Specify)_____
☐ Other Fetal Conditions/Disorders (Specify) _____
☐ Unknown

Other Significant Causes or Conditions (Select as many as apply)
Complications of Placenta, Cord, or Membrane

☐ Rupture of Membranes Prior to Onset of Labor
☐ Abruptio Placenta
☐ Placental Insufficiency
☐ Prolapsed Cord
☐ Chorioamnionitis
☐ True Knot in Cord
☐ Other – Specify _____

Maternal Conditions/Diseases (specify) _____
Other Obstetrical or Pregnancy Complications (specify)_____
Fetal Anomaly (specify) _____
Fetal Injury (specify) _____
Fetal Infection (specify) _____
Other Fetal Conditions/Diseases (specify) _____
☐Unknown

Estimated Time of Fetal Death (Select One)

☐ Dead at time of First Assessment, No Labor Ongoing
☐ Dead at Time of First Assessment, Labor Ongoing
☐ Died During Labor, After First Assessment
☐ Unknown Time of Fetal Death

Was Medical Examiner Contacted? ☐Yes ☐No

Was an Autopsy Performed? ☐Yes ☐No ☐Planned

Was a Histological Placental Examination Performed? ☐ Yes ☐ No ☐Planned

Were Autopsy or Histological Placental Examination Results Used in Determining the Cause of Fetal Death?
☐ Yes ☐ No

Certification Review

Name of Medical Examiner_____ License Number_____

Date Approved (mm/dd/yyyy) _____ ME Case Number _____

Last Updated by (Name)_____Last Date Updated _____ (mm/dd/yyyy)

Disposition Information

Method of Disposition
☐Burial ☐Donation ☐Cremation ☐Entombment ☐ Held

☐Other (Specify)_____ ☐ Unknown

☐Removal from State ☐Removal from Country

Date of Disposition#1 (mm/dd/yyyy)_____
Name of Disposition Facility:_____
Complete Address:_____

Date of Disposition #2 (mm/dd/yyyy)_____
Name of Disposition Facility:_____
Complete Address:_____

Funeral Facility

Funeral Facility Name _____

Address_____

Funeral Director _____ License Number _____

Information Updated by _____ Last Updated on (mm/dd/yyyy) _____

Date Report of Fetal Death/Worksheet Completed _____(mm/dd/yyyy)

Name of Informant

_____	_____	_____
Print First Name	Middle	Last

Signature of Informant

_____	_____
Signature	Date

Thank you for completing this worksheet at this very difficult time. The information you have provided is very important; it will be used by researchers to better understand factors related to miscarriage and stillbirth and lead to improved prevention strategies for the future.

ARIZONA TRIBAL ADDENDUM

Ak-Chin Indian Community
Cocopah Indian Reservation
Colorado River Indian Reservation
Fort McDowell Mohave-Apache Community
Fort McDowell Yavapai Nation
Fort Mohave Reservation
Fort Yuma – Quechan Reservation
Gila River Indian Community
Havasupai Reservation
Hopi Reservation
Hualapai Reservation
Kaibab-Paiute Reservation
Navajo Nation
Pasqua Yaqui Reservation
Pueblo of Zuni
Salt River Pima-Maricopa Indian Community
San Carlos Apache Nation
San Juan Southern Paiute
Tohono O'dham Nation
Tonto Apache Nation
White Mountain Apache Nation
Yavapai-Apache Nation
Yavapai-Prescott Reservation
Other